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A grounded theory exploration of social workers' permanency planning for looked after children in Scotland

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The University of Edinburgh

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Table of contents

D. Clin. Psychol. Declaration of own work.....	ii
Acknowledgements.....	iii
Table of contents	iv
List of figures and tables.....	vii
List of appendices.....	viii

Portfolio Thesis Abstract.....	1
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Journal Article 1: Empirical research study.....	4
Abstract.....	5
1. Introduction.....	6
1.1 Permanency in Scotland.....	6
1.2 Delays in permanency.....	7
2. The current study.....	9
2.1 Aims	9
3. Method.....	9
3.1 Design.....	9
3.2 Participants and procedures.....	10
3.3 Data collection.....	11
3.4 Reflexivity.....	12
3.5 Data analysis.....	12
3.5.1 Development of interviews, coding, and conceptual grouping.....	13
3.6 Validation and quality assurance.....	14
4. Findings	15
4.1 Overview of the grounded theory	15
4.2 Explanation of theoretical categories.....	16
4.2.1 Planning for permanence.....	16
4.2.2 Child's mind in mind.....	18

4.2.3 Anticipating the future.....	21
4.2.4 Emotional demands.....	22
4.2.4.1 Personal cost.....	23
4.2.4.2 Professional.....	24
4.2.4.3 Interpersonal costs.....	26
4.2.5 System stressors.....	29
4.2.5.2 Interpersonal dynamics.....	29
4.2.5.3 Contact.....	30
4.2.5.4 Professional hierarchy.....	32
4.2.6 Responsiveness.....	34
4.2.7 Recommending.....	35
4.3 Development of the grounded theory: Theoretical coding.....	36
5. Discussion	37
5.1 Limitations.....	37
5.2 Integration of findings with the existing literature and implications for practice.....	38
6. Conclusion.....	46
Acknowledgements.....	46
References.....	46
 Journal Article 2: Systematic Review	 53
Abstract.....	54
1. Introduction.....	55
1.1 Psychological processes and parenting behaviours: Mentalization and Reflective Function.....	55
2. Review question.....	57
3. Method.....	58
3.1 Systematic review protocol.....	58
3.2 Search strategy.....	58

3.3 Inclusion criteria.....	58
4. Search results.....	59
5. Results of the review.....	60
5.1 Main characteristics of the identified studies.....	60
5.2 Quality assessment.....	66
6. Main findings.....	67
6.1 Childhood maltreatment and caregiver reflective function.....	67
6.2 Parental reflective function.....	67
6.3 Adult reflective function.....	68
7. Critical appraisal.....	70
7.1 Study quality	71
7.2 Conceptual.....	71
7.3 Measurement	72
7.3.1 Measurement of childhood maltreatment.....	72
7.3.2 Measurement of reflective function.....	75
7.4 Population.....	77
8. Discussion.....	78
9. Conclusion.....	80
References.....	80

List of Figures and Tables

Journal Article 1: Empirical Study	4
Table 1. Summary of statutory orders of permanency in Scotland.....	7
Figure 1. A grounded theory of social workers' experiences of planning for permanency.....	16
Table 2. Participant demographic information.....	11
Table 3. Example of coding development.....	14
 Journal Article 2: Systematic Review	53
Table 1. Inclusion / exclusion criteria.....	59
Figure 1. Search strategy.....	60
Table 2. Summary of included studies.....	62
Table 3. Summary of quality assessment.....	66

List of appendices

Appendix 1. Author guidelines for article submission to <i>Child Abuse and Neglect</i>	86
Appendix 2. University of Edinburgh research ethics approval documentation.....	89
Appendix 3. Participant information sheet.....	90
Appendix 4. Informed consent form.....	93
Appendix 5. Text extracts of preliminary open questions.....	94
Appendix 6. Coding extracts.....	96
Appendix 7. Example of diagramming.....	104
Appendix 8. Author guidelines for submission to <i>Infant Mental Health</i>	105
Appendix 9. Systematic review protocol.....	107
Appendix 10. References for excluded studies organised by exclusion criterion.....	109
Appendix 11. Quality criteria for systematic review.....	115

Portfolio Thesis Abstract

Title

- 1) A grounded theory exploration of social workers' permanency planning for looked after children in Scotland
- 2) Experience of childhood maltreatment and reflective function of parents: A systematic review of observational research findings

Aims

- 1) Permanency planning refers to meeting the needs of a 'looked after' child by legally securing a permanent family. Delays in securing permanency are associated with adverse outcomes for children. Social workers are integral to this process and yet there is a paucity of research considering how workers make sense of this professional role. The current study aimed to develop an explanatory theory of social workers' sense making in planning for permanency to identify issues and facilitate a discussion around the experiences and needs of this group.
- 2) The paper considers childhood experiences of maltreatment in relation to adult reflective function in parenting, a variable implicated in infant attachment security. A systematic review aimed to explore the current research literature examining the association between the experience of maltreatment in childhood and later reflective function in parenting.

Methods

- 1) A qualitative grounded theory methodology (GTM) was used to analyse interviews with eight social workers who had a current permanency role (six female).
- 2) Following the development of a grounded theory via integration of the data with the theory of mentalization, a relevant systematic review was conducted. The current research literature was explored in relation to adults' experiences of maltreatment in childhood and reflective function in parenting.

Results

1) Although participants described delays in relation to systemic pressures, as analysis of interviews unfolded theoretical sampling explored their experiences of losing and maintaining ‘focus’ on the child in permanency planning. The findings generated a theory positing that workers seek to keep a child’s ‘mentalized’ experience at the fore (to hold his ‘mind in mind’) and plan responsively to make permanency recommendations while negotiating the challenges of person-centred working within a multi-agency system. Workers were found to describe holding ‘mentalized’ interpretations of a child’s past, current, and future experiences during the processes integral to planning for permanency (assessment, early decisions, information gathering, interpretation, integration, and interaction with the wider system). Holding the child’s mind in mind also contributed to the ‘strength of evidence’ for permanency planning, and was, at the same time, vulnerable to the destabilizing effects of the emotional demands and system stressors perceived within the permanency role. Permanency planning and integration of evidence to make recommendations for permanency was responsive to the complexities of interpersonal working, hypothetical futures for the child, and to the potential impact of planning actions for future decision makers.

2) A systematic search of the literature identified seven datasets (of which nine papers) presenting analyses relating to measurement of childhood maltreatment and parents’ reflective function.

Conclusions

1) The study theorised a psychological process related to holding ‘focus’ on the child in permanency and concluded with recommendations for permanency practice based on this preliminary model. These included prioritising a culture of professional empathy, training in and availability of protected reflective clinical supervision, post-adoption support for birth parents, and training in working with complex interpersonal behaviour

to better facilitate effective permanency planning and improve outcomes for looked after children.

2) Although the identified studies indicated a lack of significant association between the factors, critical evaluation of conceptual, methodological and population issues indicated that the small number of reviewed studies were limited in their capacity to address the review question. After further data reduction according to study quality and separation of analyses according to conceptualisation of mentalization there remained two datasets reporting on CM and adult RF, and three reporting analyses of CM and parenting RF. Conceptual differences regarding mentalization and RF are considered in relation to emerging areas of research in this field.

Journal Article 1: Empirical research study

Title

A grounded theory exploration of social workers' permanency planning for looked after children in Scotland

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Abstract

Permanency planning refers to meeting the needs of a 'looked after' child by legally securing a permanent family. Delays in securing permanency are associated with adverse outcomes for children. Social workers are integral to this process and yet there is a dearth of research considering how they make sense of their experiences in this professional role. The current study aimed to develop an explanatory model to facilitate a discussion around the experiences and needs of social workers who engage in planning for permanency. A grounded theory methodology (GTM) was used to analyse interviews with eight social workers who had a current permanency role (six female). As the researcher interacted with the data using GTM, interviews developed to explore experiences of losing and maintaining 'focus' on the child in permanency planning. The data generated a theory positing that 'focus' was associated with workers' descriptions of holding a child's 'mentalized' experience at the fore (hold his 'mind in mind') while planning responsively to make permanency recommendations and negotiating the challenges of person-centred working within a multi-agency system. Holding the child's 'mind in mind' contributed to the 'strength of evidence' for proceeding with permanency. At the same time it appeared vulnerable to destabilization associated with emotional demands and system stressors perceived within the permanency role. Recommendations included prioritising a culture of professional empathy, training in and availability of protected reflective supervision, post-adoption support for birth parents, and training in working with interpersonal complexity to facilitate effective permanency planning and improve outcomes for looked after children.

Keywords: Permanency planning, delay, social workers, Child Protection, Mentalizing, Grounded Theory

1. Introduction

In the context of child protection, a social worker's decision to pursue 'permanence' for a child out with the biological family is taken in response to the child's experience of a physical and emotional environment characterised by abuse, neglect or failures of protection from abuse by others. Childhood emotional, physical and sexual abuse, and physical and emotional neglect, have long been recognised as detrimental factors for the long-term outcomes of children (Mullen, Martin, Anderson, Romans, & Herbison, 1996). Maltreatment in childhood has been implicated in the development of negative epigenetic adaptations (National Scientific Council on the Developing Child, 2010), changes in brain structure and function and stress-response systems (Glaser, 2000), and is known to impact negatively on later health and socio-emotional wellbeing (Norman, Byambaa, De, Butchart, Scott, & Vos, 2012). A key moderator or mediator for these outcomes is the attachment relationship with primary carers (Bowlby, 1969; Wolff, & IJzendoorn, 1997). For maltreated children, patterns of disorganised attachment are prevalent and the effects on subsequent development and relationships can be adverse and lasting (van IJzendoorn, Schuengel, & Bakermans-Kranenburg, 1999). At the same time, in this dynamic, unfolding, developmental process, there is recognition that recovery and resilience can be fostered in contexts of safe and nurturing care (Dozier, Peloso, Lewis, Laurenceau, & Levine, 2008; Wright, Barry, Hughes *et al.*, 2015).

1.1 Permanency in Scotland

'Permanency practice', includes both "how best to stabilise families before care is needed" (p3, Centre for Excellence for Looked After Children in Scotland, CELCIS, 2014) and ensuring legally secured family membership and quality care that meets the child's needs and continues into adulthood (Scottish Government, 2015). For the purposes of this paper, 'permanency planning' refers to the processes involved in permanently removing the child from the care of birth parents. The social worker's role in permanency planning is key to a child's pre-proceedings experience and to instigating permanency recommendations to decision makers in statutory roles.

Key parties involved in permanency decision making in Scotland include local Adoption and Permanency Panels, Agency Decision Makers, the Children's Reporter, and the Children's Hearing Panel. The process continues under the legal oversight and authority of the Sheriff Court. Outcomes for children involved in permanency processes include rehabilitation (return to birth parents with ongoing support where appropriate), or statutory orders of permanence. In Scotland, statutory orders fall into four subtypes under the revisions enacted in the Adoption and Children (Scotland) Act 2007 (summarised in Table 1). Use of these legal processes can vary according to individual need and by local authority convention.

Table 1: Summary of statutory orders of permanence in Scotland

Statutory Order	Description
Permanency Order (PO)	Allowing for distribution of parental rights and responsibilities appropriately between the birth parents, local authorities and foster carers or kinship carers
Kinship Care Order	Transfer of parental rights to a family member
Direct Adoption Order (AO)	Petition by adopters freeing the child to become a full member of an adoptive family
Permanency Order with Authority to Adopt (POA)	Petition by the local authority freeing the child to become a full member of an adoptive family

1.2 Delays in permanency

In a UK family justice context, Brown and Ward (2013) have described the view that the dynamic nature of child development and the developmental trajectories implicated by early relational experiences are at odds with the oftenlengthy procedures of due diligence required in pursuing permanency. The paper reports that in England it takes on average two years one month to achieve permanence (in the form of adoption) after a

child first becomes looked after. In Scotland the evidence suggests a similar picture (Scottish Children's Reporter Administration, SCRA, 2011a, 2015a). In a Scottish sample of infants identified before birth (SCRA, 2011b, 2015b), 36% had an interval of less than two years between identification of permanence and granting of an Order. For some this process took more than seven years. Time intervals varied by the type of Order pursued, with more children on POs facing longer delays. Within these timescales, nearly half had had at least three placement moves before they moved to their final adoptive home, and over a quarter had at least four moves. One child had 15 moves (p48).

Crucially, delays impact on a child's chances of being adopted (Selwyn, Sturgess, Quinton, & Baxter, 2006). Age at adoption is implicated in the risk of later disruption or breakdown of the adoptive placement (Boddy, 2013; Selwyn, Wijedasa, & Meakings, 2014). Placement disruptions too are linked to poor long-term mental health outcomes (James, Landsverk, Slymen, & Leslie, 2004). Pritchett *et al.*, (2013) describe how "many maltreated children "revolve" between birth families and foster carers" (p1) in a system which does not facilitate prompt decisions about permanent placement and further undermines the development of secure attachment relationships. Although guidance on the 2007 Act states a six-month timescale to formulate a plan for a child to return home or to seek permanence elsewhere, recent Scottish data suggested that this was met for only 33% of a sample of 200 cases (SCRA, 2015a).

Social workers play a key role across all aspects of planning for permanency. Despite this, there is a paucity of research that considers the qualitative experience of the social worker in child protection (Kettle, 2013) and less still for those working within permanency practice. At the same time White (2011), discussing reasoning and judgement in social work, states "If we are to have a debate about what might be done, it must start with some clarity about how social workers in their day to day work 'think'" (p183).

2. The current study

Research by the Scottish Court Reporter Administration (SCRA 2011, 2015) concluded that, alongside delays in the legal process, significant delays also occurred at early stages of decision making around whether to formalise permanence planning. In England, Ward, Brown and Westlake (2012) too have described pre-proceeding delays that accrued when workers postponed taking ‘decisive’ actions.

Conceptual frameworks developed regarding decision making processes in child protection have discussed analysis of information within the interrelated contexts of the individual, organisation, resources, constraints, case, and external factors (Barlow, Fisher and Jones, 2012; Bauman, Dalglish, Fluke and Kern, 2011; Munro, 2005). These models suggest that factors contributing to ‘human error’ within systems are a starting place for better understanding child protection decision making. For permanency working, in-depth exploration of how social workers ‘think’ in the day to day of permanency to unpicks the “informal processes” (Broadhurst, Hall, Wastell, White, & Pithouse, 2010, p16) at play may add to our understanding of decision making in this area. Ultimately, generation of theory drawn from social workers’ sense making of their experiences of practice in this complex and emotive area may point to practical interventions that support effective permanency planning and positive outcomes for vulnerable children.

2.1 Aims

The aim of the study was to explore social workers’ permanency planning for looked after children in Scotland.

3. Method

3.1 Design

As the study aimed to develop an explanatory theoretical model based on the experiences of the studied population that might be applied practically, grounded theory

method (GTM) was chosen (Charmaz, 2014). GTM has been used previously to study parallel populations including children and families social workers (O'Connor & Leonard, 2014) and child protection social workers (Kettle, 2015) to explore decision making in these contexts. As a distinct methodology, rather than generating theory via hypothetical deductions, GTM researchers develop a substantive theory using inductive and abductive analyses of the data (Giles, De Lacey, & Muir-Cochrane, 2016). These analyses apply the tenets of data collection, coding, memoing, theoretical sampling and constant comparison in a recurring pattern in order to explore participants' meaning-making within a given context. In doing so, GTM aims to generate a conceptual theory with practical utility where explanation is based on the experiences of the population and context studied (Birks & Mills, 2011). A social constructivist interpretation of GTM (Charmaz, 2014) that emphasised the emergence of theory "through the interaction of the researcher and the researched" (Weed, 2009, p508) was applied. Using a constructivist interpretation, researchers seek to acknowledge preconceptions or biases, utilising these to increase sensitivity to conceptual possibilities within the data, whilst also striving to maintain an open mind to alternatives and revisions. The 'fit' between the constructivist account and the researcher's own stance towards the underpinning epistemological assumptions relating to construction of knowledge (Walsham, 2006) further influenced the choice of methodology.

3.2 Participants and procedures

The study employed initial purposive sampling of social workers from a Scottish children and families practice team which included professional roles including practice workers, senior practitioners, team leaders, management, legal advisors, support workers and a clinical psychologist. Inclusion criteria were: English speaking social workers who were currently active in the permanency process, and who had worked within permanency for more than one year.

Identification of a potential recruitment pool began after ethical approval was granted by the local authority's social work research ethics administrator and the University of Edinburgh Ethics Committee (Appendix 2). Participants were recruited following informed consent procedures (Appendices 3 & 4) and a total of eight social workers from the potential pool were recruited (Table 2). Theoretical sampling (Glaser & Strauss, 1967) guided subsequent data collection as coding and analysis developed. For example, interview three indicated this worker's sense that the emotional experience and demands related to working in permanency differed now that she had accrued eight years of permanency working. Sampling was then directed to ensure that workers with fewer (participants four and five) and greater years of experience (participants six, seven and eight) were sampled. In this way, the final sample included a mix of males and females and workers currently in direct practice or managerial/supervisory permanency roles. Interview questions also developed alongside analysis.

Table 2: Participant demographic information

Participant*	Gender	Permanence role	Years since qualified	Years of permanency case-work
SW1	M	Senior practitioner	9	3
SW2	F	Senior practitioner	10	5
SW3	F	Senior practitioner	12	8
SW4	F	Team Leader	10	2
SW5	F	Manager	23	2
SW6	M	Manager	24	10
SW7	F	Senior practitioner	9	9
SW8	F	Senior practitioner	30	14

3.3 Data collection

Data collection continued in an iterative cycle of interviewing, coding and further interviews over a 10-month period. Interviews were conducted in a meeting room at the participant's workplace, with the exception of one which took place in a local café, and

ranged from 50 minutes to 1 hour 29 minutes. All interviews began with questions regarding the worker's current role (brief description, number of years in role, previous experience) before inviting responses to an initial open statement: *'I'm interested in hearing about what it's like for you as a Social Worker working in your role in planning for permanence'* (see Appendix 5). An open-ended, in-depth, facilitative style was maintained to encourage co-construction of the interview. Prompts were given to guide participants towards discussing case examples of practice work in order to develop autobiographical description of the experience.

3.4 Reflexivity

The researcher, in keeping with the guiding concept of 'reflexivity' (Charmaz, 2014), sought to make explicit the nature of her own influence on the research process. At the time of the study, the researcher was a clinical psychology trainee on placement within a child and adolescent mental health trauma service. The researcher has a background in developmental psychopathology research and draws upon psychoanalytically informed thinking in her practice. A mother to three children, she had had no personal contact with social work services, however professional contact with social workers was frequent while supporting clients, some of whom were looked after or accommodated. Before undertaking interviews, the researcher familiarised herself with the legal routes to permanency but consciously did not pursue the literature in detail to avoid forcing concepts or preconceptions. Interviewees were aware of the researcher's professional link as supervisee to co-author (TPT), a clinical psychologist working with the social work team.

3.5 Data analysis

Digital recordings of interviews were transcribed close to the date of interview by the researcher. Data were pseudonymised and audio files deleted. Verbatim transcription of the interviews by the researcher allowed for an immersive engagement with the content. Memos were written after interviews in order to record the meaning of codes, link

concepts, ultimately referring to extant theories, and to increase research transparency (see example in Appendix 6). Diagramming was used to illustrate links between codes and guided integration of the data with explanatory theories (Appendix 7).

3.5.1 Development of interviews, coding and conceptual grouping

An Excel spread-sheet containing text, codes and emergent theoretical categories was developed to aid data management. Line-by-line analysis of the first two transcribed interviews generated initial codes to ‘fracture’ the data and nascent, low-level focussed codes were identified (see Appendix 6). Initial codes were developed quickly, where possible using gerunds and worded similar to the verbatim content (Charmaz, 2014). Related codes were grouped into categories and used to generate new interview questions. For example, after initial coding of SW1 and SW2 saw initial related codes around ‘maintaining focus’, subsequent interview questions were posed sensitive to exploring this further such as to SW3: *“what do you think you mean there about “looking” at the child?”* or to SW4: *“Losing sight of the child? What is it that gets lost?”*. Theoretical categories developed through a process of constant comparison between data and codes, supported by field notes and memo-writing, were taken back to new participants in subsequent interviews. Here they were explored, compared and further refined and subject to confirmation and disconfirmation by actively seeking ‘negative cases’ that did not demonstrate emergent theoretical categories.

Alongside coding, memo writing and reflection on field notes helped the researcher to examine and question the interviews analytically to generate higher-level categories (Table 3). Where data accumulated densely around a core category, interview questions became more focussed in a process of selective coding. Relevant data that added value to the core category were added as coding continued until codes reached a stage of ‘theoretical sufficiency’ (Dey, 1999). In this way, data collection and coding moved towards a position whereby new codes could be considered within existing theoretical categories.

Table 3: Example of coding development

Quote	Initial code	Focussed code	Category	Overarching category
"It is about being part of the loss. It's being part of removing a child permanently and in that way it might be like dying as a parent" (SW6, para 56)	Being part of the parent's emotional reaction to loss	Taking personal responsibility	Personally demanding work	Emotional demands of permanency
"their potential to form secure attachments it's less obvious to people...it's harder to explain and see" (SW1, para 166)	Can't see attachment vs. can see parents	Can't see child's internal world	Considering child's internal world	Child's mind in mind

3.6 Validation and quality assurance

Respondent validation was sought to assess the emergent theory's fit with participants' experiences in order to improve the study's rigour and to check transferability. The emergent theory was presented to participants verbally or via an email illustrating the model and describing the main findings and participants were invited to comment. The findings and model were also presented verbally to two clinical psychologists who had a professional role within the practice team. Social work participants who opted to respond (n = 4) and the psychologist respondents agreed that the model reflected their experience of practice within the area of permanence. Further quality assurance was provided by audio recording of interviews to increase accuracy, personal transcription of interviews, maintenance of a reflective diary, independent coding of select sections of transcripts, and discussion of the emergent theoretical categories with individuals experienced in the qualitative method.

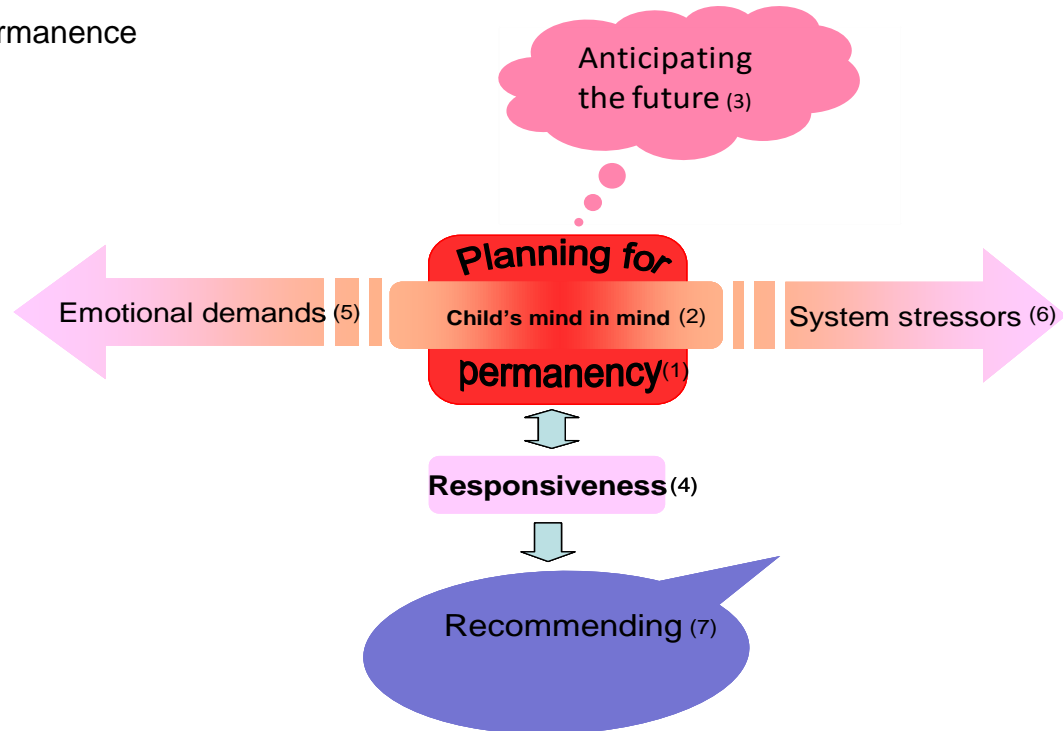
4. Findings

Figure 1 illustrates a substantive grounded theory model of the experience of social workers engaging in permanency work. Main categories are presented in section 4.2.

4.1 Overview of the grounded theory

Illustrated in Figure 1, the central organiser ‘planning for permanency’ (1) summarises the elements of social work practice workers referred to in proceeding towards permanency. These included assessment, information gathering and integration, early decisions regarding placements and contact, and, interaction with the wider decision making and legal systems. Alongside emphasis on child protection concerns around overt physical risk and safety, early decisions regarding placement and contact, and evidential strength to proceed with permanency were associated with workers’ references to the effect of the child’s experiences on his current and future psychological and emotional safety and wellbeing (‘child’s mind in mind’ (2)). Contributing to this was the process of ‘anticipating the future’ in terms of the influence of factors associated with the permanency process on a child’s development, and regarding anticipated future responses of the permanency system to early decisions regarding placement and contact (3). Actions taken by workers in ‘planning for permanency’ and interpretation of information as evidence to make recommendations for permanency involved a process of ‘responsiveness’ (4) which accommodated the complexities of interpersonal working alongside negotiation of anticipated future for the child and the requirements of the legal system. At the same time, in engaging in the practice necessary for ‘planning for permanency’, workers managed ‘emotional demands’ (5) and ‘system stressors’ (6) arising from the permanency role. These experiences in turn exerted a dynamic effect upon the workers’ task of keeping permanency planning focussed on the child’s experience (‘child’s mind in mind’) within the permanency process. Making a decisive recommendation for permanency was associated then with these complex interactions around interpretation of information as evidence that held the child’s mind in mind (7).

Figure 1: A grounded theory of social workers' experiences of planning for permanence



4.2 Explanation of theoretical categories

The following details the core theoretical categories and subcategories developed in the analysis of the interview data, although there is inevitably overlap and complexity. Interview excerpts are presented to increase transparency and illustrate the emergence of a central mechanism and conceptual links arising from the data. Although interviews were populated by descriptions of systemic factors that influence delays such as limited resources and pressures around workload, the findings below sought to describe workers' sense making around the emergent emphasis on 'focus' in relation to permanency planning.

4.2.1 Planning for permanence

'Planning for permanence' represented the practice elements of assessment, information gathering, early decisions regarding placements and contact, integration and

interpretation of information, and interaction with other professionals and the wider permanency system, that social workers described. Proceeding with permanency as a path was associated with perceptions of the ‘strength’ of the evidence developed from these processes:

“if...the evidence is clearer that will probably make the process quicker, if one has clear evidence of that child not being parented properly, it will tend to make one more confident in forging ahead at a greater pace towards permanence” (SW6)

Interviews described evidence in terms of risk to the child and the need for physical safety in line with general child protection working. However, evidence for permanency cases was also related to understanding parenting and capacity for change and events that the child had experienced, in addition to the worker’s interpretation of the impact of experiences within the birth family on the child’s past, current and future wellbeing:

“...the evidence is what has happened, the abuse and or the neglect...and...but what the negative impact of that has all been for the child...attachment and his development...and how we can make predictions on what might happen next for him, in the future, if nothing changes” (SW1)

Within descriptions evidencing the impact of the child’s experience in this way, workers talked of moving beyond the descriptive to interpret the child’s past experiences and current circumstances in terms of likely psychological and emotional impacts:

“Because it’s not all this description stuff about shiny hair. {Okay} The reports show the evidence and meaningful analysis of the child’s experiences and issues and how things really are and how they can be addressed and what they need” (SW5)

4.2.2 Child's mind in mind

In early interviews, workers discussed variously 'losing' or effortful maintaining of 'focus' on the child for the permanency system:

Sometimes you've really got to focus on the child {mmmm}. Otherwise I think sometimes they get a bit lost in the...in the eh...in the meetings" (SW1)

Interviews sought to explore workers' sense making of 'maintaining and losing focus' on the child in this way. Analysis of commonalities, discrepancies and interactions between codes developed the sense that 'focus' was associated a process of considering what the child "carries along inside him" i.e. his psychological and emotional developmental experience.

"...I think it was about people generally getting focussed on the parents and losing sight of the child who is still waiting. [...]" (SW4)

"What is it that gets lost? Can you tell me more about that?" (Interviewer)

"That there's this small person here who...while this or that is happening with the parents or this or that is happening with the processes here...this child has likely had a life so far with things that have happened that he carries along inside him and they will continue to affect him into the future" (SW4)

Codes relating to the "meaningful analysis" (SW5) of information in relation to the child's experiences were grouped within the theoretical category of focussing on the child's 'mind in mind' within permanency working. This theoretical category considered workers' descriptions of the child's past, current and future wellbeing across behavioural, emotional and psychological domains. Within this, interviews relayed a sense of interpreting the emotional or psychological impact of the child's experiences by 'stepping into the child's shoes' emotionally or psychologically (holding his 'mind in

mind’). For example, SW2 described this in relation to a child’s experience of placement instability:

“Because it wasn’t fair on them...they were having to make and break with fosterers, they were only wee but you’d guess that they’d learnt not to believe that mum or anyone would stay around and they...emotionally...the stress of all that for them. So many people coming and going and disappearing” (SW2)

Workers appeared to be holding the child’s ‘mind in mind’ to interpret information gathered. For example, SW3 reflected on the child’s experience in this way following a complex interpersonal interaction at a home-visit:

“Em, but he’s sitting there he’s going ‘PUT her DOWN’ [firmly] to the mum and...the mum...did it...put her down, on the floor and of course she took one step in to the middle of the floor did it again, did the splits you know on the floor and cried. So, what’s she thinking? ‘I hurt myself last time but dad says do it and I get put on the floor by mum and I’m hurt again...dad’s in charge here and if he wants me to get hurt its ok’ [...] You know I thought, that just proved to me how dangerous he was really, you know, that he would do that. Just to prove some kind of point to me {mhmmm} and to make her feel like that like she was his to use” (SW3)

In this example, SW3 interpreted both the parent’s behaviour and the child’s internal experience of it and then integrated this into the weight of evidence for pursuing permanence. Similarly, in considering the child’s experience of contact with a birth parent, SW4 described drawing on the internal states behind the behaviour of a fostered baby in her decision making to pursue permanency:

He was all over the place in contact and couldn’t cope in the placement afterwards. They were seeing him overwhelmed and more erratic, less able to settle for sleep and he

wouldn't eat. And we were seeing that for this wee boy, time with mum meant confusion and being overwhelmed to the point where he was so wound inside up he wouldn't even eat. So, it [reunification] couldn't happen because of what we were seeing there and because of how mum was" (SW4)

Also, evident in the interviews were examples of workers considering the child's internal world in relation to hypothesised future behaviours in a way that informed permanency practice. For example, SW1 discussed concerns regarding a child's future behaviour in placement and relationship disruptions in the context of the imperative to work well interpersonally with birth parents:

"When that...when that 10-year-old child is learning a bit of their background trying to understand themselves, who they are, what was written in that report all those years ago is going to be...every little sentence is going to be...kind of analysed potentially...read between the lines. Any information that isn't there will be filled in with...fantasies potentially that might mean more confusion and behaviour problems in the placement potentially and another relationship breakdown if it's not supported" (SW1)

When workers described cases where the focus on the child's 'mind in mind' was reduced this was associated with a sense of cases stalling as decisions were deferred or delayed:

"Workers need to show how the baby or child is growing up emotionally because of what is happening around him and what the outlook is for him then. And without being totally on it with that kind of thinking the cases can stall because it isn't as clear what the issues are" (SW5)

Workers also described keeping the potential for a child's 'mind in mind' perspective to become more difficult in the face of complexities. For example, describing work with a

baby exposed prenatally to chronic stress via domestic violence and maternal drug use, SW8 considered foster carer's reports that the baby was behaviourally very irritable and required a higher than average level of caring. This was interpreted as suggestive of emotional development and behaviour that might interact negatively with his birth mother's parenting capacity. Thinking about the child's behaviours in this way was associated with having made a definitive decision to move forwards to recommend permanency:

"[the baby's] development has gone on before he was born with the assaults and with mum's drug use. That's what the fosterers are seeing and dealing with now [...] being so unsettled and crying and needing kind of intensive parenting [...] Well so we need to put it all in the report that...that complexity and we see...well...we see that it all has already been damaging for him and the likelihood is that damage will keep piling up if all those other issues mum has not managed to break free of are piled on top. We need to focus on seeing that, otherwise decisions are harder to reach in the face of all of that" (SW8)

4.2.3 Anticipating the future

Social workers described 'anticipating the future' in terms of parental change, in relation to the impact of the permanency process itself on factors influencing the child's development, and in the context of anticipating the responses of decision makers. Workers were mindful of the impact of delays on children's outcomes, particularly in relation to experiences of stability in placements. For example, SW1 described anticipated the effects of 'time passing' during planning in terms of a child's ongoing socioemotional development and on chances of adoption or of placement breakdown:

"It's really frustrating. It's knowing that the delays are affecting the child you are working with and that time passing means they're getting older and that might make it harder to find an adoptive match" (SW1)

Workers also referenced anticipating the potential future responses of the permanency system. For example, early decisions regarding where to initially place a child were described as involving a balance between awareness of the child's need to form secure attachment relationships with permanent carers as quickly as possible against anxieties around potentially delaying proceedings by incurring consequences should the system perceive 'pre-empting' of what is a legal decision:

"But it's almost like some panel members get really scared if you're looking to move a child for adoption reasons, because they'll say 'That's pre-empting a court judgement'"
(SW7)

The anticipated future impact of social work recommendations and panel decisions regarding contact between birth parents and the child, and the potential impact of continued contact on permanent carers' attitudes towards a placement represented an additional unknown to be held in permanency planning:

"We're further down the permanence route and we're looking for potential permanent carers, if there's a level of contact at that level, one cannot with confidence predict what the level of contact might be post-granting of a permanence order if that is given. And it can reduce the pool of potential carers if we're not clear about contact arrangements"
(SW6)

4.2.4 Emotional demands

Although the number of permanency cases on participants' case loads was relatively low, workers relayed a sense that they were experienced as emotionally heavy which impacted at times on practitioner wellbeing:

“You can have many nights where you’re in your bed and your eyeballs are just like, you know, bouncing out of your head. Because you’re not relaxed. You’re constantly turning everything over in your head” (SW7)

Subcategories housed under the theoretical category of ‘emotional demands’ were described across personal, interpersonal, and professional domains. Examples of the interaction of these subcategories with descriptions of losing focus on the child’s ‘mind in mind’ populated interviews. These are described below:

4.2.4.1 Personal cost

Participants described a ‘personal cost’ to working in what can be emotionally charged situations with people in distress. Traumatic events manifest in the form of threats to self or loved ones, interpersonal conflict, and potential symptoms of vicarious trauma were described. Examples in the following quotes illustrate these experiences:

“And I had to phone my son’s school to alert them to the fact that they may, you know, make... You know, I was worried about them tracking him down” (SW7)

“Well, they’d let me in a couple of times but it’d only really been to shout at me [laughing] you know” (SW3)

“It can impact on your sleep. There have been times where, in the past, as a worker, I’ve woken up worried about, erm... those [cases]” (SW5)

Further, cognitions were voiced that suggested social workers held a sense of personal responsibility for the losses of the child, birth parents and adopters. This burden appeared to sit heavily emotionally and added to the emotional demands of the permanency role:

“Because there have been times when I’ve thought, you know ‘what am I doing? What kind of job have I chosen to do when you’re causing someone so much pain?’” (SW2)

Memos referred variously to interpretation of the interviews that linked social workers’ experiences of permanency working to attachment theory (Bowlby, 1969) which emphasises the child’s experience of loss. In particular, the researcher noted the central role of loss in permanency work: the child’s loss, birth parent’s loss, the adopter’s fear of loss, and the social worker’s loss of identity. It seemed that workers in the current study held a sense of personal responsibility for their role in this process of loss making. The following quote from SW3 demonstrated the sense that holding responsibility in this way was associated with pulling focus away from the child towards the parent’s experience in interpreting information as evidence:

“she’s a ‘poor wee lassie’ you know you kind of, your heart strings are pulled by her. And of course, the thing you’re doing is taking away her self as a parent, stopping her being a parent to her own child. And that’s really hard to do to a poor wee lassie. [...] And your heart does go out to her. You know, any human would go out to her. I suppose the child can then get a bit lost in amongst all that [...]” (SW3)

Although describing personally difficult experiences in court that were coded under the system stressor category, SW6, was a negative case in terms of personal costs associated with permanency work.

4.2.4.2 Professional

Beginning as a worker ‘new to permanency’ and moving towards becoming recognised among one’s peers as an experienced permanency worker was described as emotionally demanding at both ends of this process. Being new to permanency represented a difficult stage where workers described being faced with emotive situations where they had wished for greater experience of permanency work:

“At first I was quite tentative and thinking ‘well I know nothing about all this. I’m new to permanence.” (SW3)

Becoming ‘known for permanence work’, on the other hand, brought additional workload as social workers described becoming a support for less experienced workers:

“And I have never been so busy ping-pong e-mails and templates and examples of PO's and POA's to people just to help them” (SW7)

Workers described how working fewer previous permanency cases was associated with intensity around identifying with the emotional impact of permanency for birth parents and an associated shift away from focus on the child’s developmental experience:

“Because otherwise I think...as new workers I think...it’s a horrible thing to do to remove a child permanently and to talk...and you know you’ve got to do it for the best outcome for the child’s future and you’ve got that eye on how he is developing of course but you hate upsetting the parents. Because you know you’re, you’re...you know it’s really hard. So, I think that as a new worker you, that’s why I ended up saying ‘why don’t we give the child back to that mother?’ and now here we are back again. And that’s what I did previously and that’s why I ended up putting the child back” (SW2)

The interviews demonstrated workers’ professional ethos regarding supporting and maintaining families. Emotional demands stemming from professional aspects of the permanency role were further described with a sense that deciding to plan for permanency represented in some way an end to the optimistic view that ‘change is possible’ for the child in relation to the birth family. Recognising this outcome for the parent appeared represent a challenge to workers’ sense of their professional identity that was seen as competing with focus on the child:

“Like when the worker has to be both keeping that focus [on the child] and wanting to believe in the parents because believing that we can support people to change is why we are here.” (SW5)

Workers also reported their experiences of anxiety around the professional role in relation to cognitions that they may be held professionally accountable within their permanency practice and face negative professional consequences in case of adverse outcomes stemming from their permanency practice. For example, SW8 described concerns regarding plans in England under proposals in the Children’s Bill to hold social workers legally accountable in child protection work. Workers’ variously reflected on this preoccupation and the effect it may have on workers’ capacity to focus on the child. SW5 in particular reflected candidly on this:

“I think it’s probably inevitable that workers mix...it’s in the mix- One is never totally focusing on the case if we are honest if - In the battle, at that stage, you can’t just be totally focusing on what’s in the welfare of the child. You’re thinking about your own wellbeing and your own practice and performance and your own stress” (SW5)

4.2.4.3 Interpersonal costs

Workers reflected on interpersonal relationships and the interpersonal skills necessary to support planning for permanency. For example, workers reported using interpersonal skills to support the child and the child’s system practically and emotionally, at times drawing on the worker’s own emotional resources:

“After every Hearing I email them [adopters] and kind of summarise (bullet points, I spare them the gory details. I hold those parts myself” (SW3)

Workers described working interpersonally with birth parents too in order to foster an outcome for the child that allowed his sense of identity to develop based on adequate life-story information and, ideally, an experience of being ‘freed up’ to be part of a new family. Interviews referred to the skill required to communicate information honestly, often with individuals who may be distressed and defensive, to meet this need for the child:

“And what I found when I came into this type of work was that, erm, it's much more emotionally draining because you're, you know, you're being asked to build up relationships with the people whose children you might ultimately end up taking away” (SW4)

Actively managing often complex interpersonal dynamics with birth parents was described in relation to workers’ sense of the emotional burden of permanency work. Reflecting on these dynamics seemed uncomfortable to pin down for workers and was discussed variously as *“the difficult characters”* (SW4), *“psychological stuff”* (SW3) or *“personality”* (SW8), or was noted in unusual ways: *“she was very manipulative [hushed tone] and very bright”* (SW2). Descriptions of these interactions with birth parents were interpreted by the researcher as having the quality of ‘process laden’ communications that could be disorganising at times, and required emotional reserves to manage. Examples included discussions of situations where workers had experienced unusual emotional reactions in relation to interactions with a birth parent:

“...and he did it deliberately... he did it to get at me you know..{provoking you almost?} Aye, you know I... I knew he'd done it to get at me. It was like he was trying to rile me and goad me into giving him a row in front of my boss [...] Because we came out of that 'cause I just went, I stood outside the front door and I was, I was crying. And I thought I've never felt this emotional about a case ever” (SW3)

In contrast to this, workers also described interactions with birth parents that were characterised by feeling intensely sympathetic:

“I’ve got another one that I’m doing at the moment and...[sigh]...that’s a really tough one. ‘Cause mum, I really like and I feel so sorry for this poor mother” (SW2)

Interpersonal dynamics between workers and birth parents were linked in the interviews to workers identifying reduced focus on the child’s experiences in planning for permanency. Being optimistic and ‘hoping for change’ in the parent, alongside the worker’s sense of their professional identity it seemed, acted to pull focus towards the parent’s experience:

“but we were so wanting it to work that what was actually happening for them [the children]...emotionally while that was all going on... well... we were focussed on giving mum another chance...and that meant that it took longer to get to this point [permanence]” (SW7)

When the interpersonal dynamic with a birth parent was characterised by conflict, effortful practice to manage professional fall out was described. Workers noted that ‘defensive practice’ to manage accusations of misconduct, or conflict aroused within the wider team, had the potential to ‘side track’ attention away from the child’s experience:

“So how does it feel when you do have to work like that? What does it mean for the case?” (Interviewer)

“[...] But for the case? It’s a lot more effort. It’s more effort instead in to covering your back and making sure you are transparent in all you working in order to keep the case on track and not side tracked into fighting off accusations and away from the thinking about the child at that point...that permanency is the plan because that’s what your assessment of all the evidence says is best for the child” (SW3)

4.2.5 System stressors

Social workers anticipated and actual interactions with the permanency system were often described as a source of stress: *“really stressful”* (SW1), *“very frustrated”* (SW2), *“it’s so exhausting”* (SW3), *“I said to him ‘I’ve never felt like walking away as much as I do now’”* (SW7). Codes reflecting workers’ perceptions of stress associated with the wider permanency system were conceptually grouped within the theoretical category ‘system stressors’. In addition to systemically derived stressors such as limited resources, process demands, and workload pressures, workers described experiences which appeared to interact with efforts to focus on the child’s experience when interpreting information as evidence, and in relation to perceptions of the wider system’s capacity to keep the ‘child’s mind in mind’ in decision making. These subcategories of experience included ‘interpersonal dynamics’, ‘contact’ and ‘professional hierarchy’ and are illustrated in the following section:

4.2.5.1 Interpersonal dynamics

The interviews demonstrated workers’ perceptions of the needs of the child becoming lost in interactions between the interpersonal dynamics of birth parents on the decision-making arms of the permanency system. Workers referred to indirect (e.g. repeatedly citing barriers to attendance) and direct (e.g. distress or hostility) interpersonal engagement of birth parents with Children’s Hearings Panels or Court which were held as potential contributing factors to delays in permanency decision making. SW4, for example, described indirect effects of “personality” on deferred Hearings:

“the personality factor I suppose, is a big one. And I don’t know if everyone would be comfortable saying that but I saw it. I was there. I mean, I could see it straight in front of me, you know? We’d go in and I’d think ‘Ah, no, here we go, here we go’... on and on and on it [deferred hearings] went” (SW4)

In describing direct interaction between permanency decision makers and the “personality factor” workers perceived that interaction with birth parents at Hearings increased ‘focus’ on the parent’s experience with subsequent delay for the child. For example, SW4 described her perception that panel members must be ‘strong’ to remain focussed on the child’s experience in the face of a parent’s distress:

“So it kept getting put off and put off and put off, the decision making, because they felt she was very volatile. [...] and people were quite afraid of upsetting her, and also knowing that she appeals everything. I guess she was invoking quite a bit of sympathy although she’s a very difficult woman to deal with, you know. All of her other children have been removed from her, so this was number five, and every time we turned up at a hearing there was one thing. Either mum wouldn’t turn up or dad wouldn’t turn up or there’s no solicitor here so we can’t go ahead. Mum would say ‘I didn’t get my papers’ or dad would say ‘I didn’t get my papers’. So it was all that delay. [...] Because they can be quite powerful characters, and unless you’ve got a really strong panel...unless you have that then the focus might be more on what is going on there, for the parents in the meeting and less about what the evidence itself says about the child I think” (SW4)

Thus, workers’ interviews conveyed the perception that the capacity to focus on the child’s experience (to hold the child’s ‘mind in mind’) may be a mechanism that affects all contributors in permanency forums in the face of interpersonal complexity. While this was noted generally in the context of delays for panel meetings, workers also reflected on experiences of this in relation to contact arrangements as described in the following section.

4.2.5.2 Contact

Workers described their role in making recommendations for levels of contact with birth parents to decision makers that were upheld or altered. They reflected on holding the current and future benefits or potential negative impacts of contact for the child

alongside future impacts on finding an adoptive match. In this way, concerns about contact were to be weighed up against an understanding of the benefits of contact for a child's ongoing development and identity formation:

"...the benefits of contact for the child...it can help a child have a sense of who they are... they have a story of who they are" (SW3)

At the same time, when reflecting on their interactions with the wider system, workers conveyed a perception that contact decisions were at times made at the expense of considering *"what it might be like for that child"* (SW4), that is, without holding the child's 'mind in mind' in focus:

"I don't think that people actually realise. They say 'oh yeah, contact with dad once a week, contact with mum once a week, contact with siblings...' And you think 'oh yeah, they all sound good'. But then when you actually set our case and think about what that week is like for the child...it's a lot of disruption going between people and places and maybe nursery on top or holidays the fosterer can't take them on so they go to another carer [...] And that's like, really, disruptive to...you know adding those things together... to the child's sense of 'who looks after me? How do I fit in?'" (SW8)

Workers interviews around negotiating levels of contact with the wider system were associated with descriptions of uncertainty and stress. It appeared that workers held a sense that concerns regarding contact decisions were at times perceived as related to decision makers' struggles to hold the child's position (broadly, his 'mind in mind') in the face of themes around uncertainty and loss:

"...contact decisions can sometimes seem to be about well about trying to make it easier for the parent because it is so awful for them to be in this situation on top of all the rest that life has thrown their way. But we have to think well what is the purpose of contact,

what is it doing for the child, will it be helpful in the longer term, what do we see for the child at and after contact times now? We need to think about the child in all of that first“ (SW8)

“Quite often it feels that people want to keep some kind of parental contact involved because nothing’s certain yet.” (SW7)

4.2.5.3 Professional hierarchy

Social workers perceived their profession as one held in relatively low esteem within a ‘professional hierarchy’. This perception was evident in attributions made regarding the weight afforded to social work evidence relative to that of other professionals, and in workers’ reported experiences of the court system. A sense of frustration was notable in interviews which described a challenge to the social worker’s role as ‘expert’ and of feeling undermined and ‘less than’ in relation to other professionals:

“But, also, I think social workers are not held in the same esteem as clinical psychologists or doctors or lawyers or psychiatrists or specialists. And that means that perhaps there is a feeling that our reports aren’t considered... aren’t held in the same esteem” (SW6)

Workers referred to other professionals being called on by decision makers in particular to interpret or add weight to social work evidence which was variously perceived as helpful or as undermining. Participants described holding this perception while facing the adversarial nature of questioning within the court setting as part of planning for permanency. In this context the interviews described respect for due process while at the same time conveying experiences of having felt professionally undermined or personally vilified:

“You’ve got the additional hierarchy of court when you’re dealing with permanence, which is very obvious and in your face, you know, and you’re treated like second rate.”
(SW7)

Having had no direct experience of appearing in court, participant 4 was a negative case in this category in terms of describing personal experiences.

Interacting with this sense of being held in low esteem professionally, and anxiety regarding experiences in the court setting, workers described their experiences within an adversarial system that ‘spoke a different language’. For example, the perception of different priorities of the legal system in the court setting appeared to contrast with what SW7 ‘brought’ to the process, that is, presenting evidence that attempted to hold centrally the child’s experience:

“it felt like I was part of some kind of theatre or merry-go-round in court, you know, it felt almost like there was a bit of a theatrical- It was like going to a theatre where the lawyers and solicitor and judge all had their own speak and their own language and their own way of doing things that didn’t match what I’m bringing [child’s experiences]” (SW7)

Workers described a sense of their role within the legal arena to focus on the child’s experiences to facilitate permanency. At the same time they described the perception that adversarial questioning weighted them towards defending procedural points of practice:

“because when you are constantly defending your practice, when you did this form or that and ‘how can you draw conclusions on that contact when you didn’t directly see it?’ and ‘well you’re not really an expert are you?’, you are not getting to say...it should be

you giving evidence about how this child has been affected physically and emotionally by these relationships” (SW2)

Similarly, workers noted the impact of an adversarial court system on their role in focussing on the child:

“[...] because when your focus is very much the child, and yet you go to court and you’re treated like a criminal actually. You’re treated like someone who needs to be spat on, and I had two opposing solicitors really laying into me with different approaches.” (SW7)

In this way, the workers’ descriptions of their role in recommending permanency using the child’s experience or holding his ‘mind in mind’ recognised that due legal process that holds parental rights alongside child welfare concerns represented a stressful balance within the adversarial court process.

4.2.6 Responsiveness

The theoretical category of ‘responsiveness’ grouped together participants’ descriptions of bridging the gap between working within the parameters of the legal system, adapting to the individual needs of each case, and moving forward with the processes of planning for permanency. Codes relating to ‘responsiveness’ were observed in workers’ descriptions of balancing the need for due process and working within the constraints of the legal processes while meeting the emotional needs of the child. For example, this was noted this in relation to working with legislation:

“So that’s important that we know that and we know what our parameters are there [legal system]. But also that we could be creative with the law in a case in the best interests of the children” (SW5)

It was also noted specifically in relation to initial placements for children where a legally ‘cautious’ approach was contrasted with seeking to minimize disruptions for the child:

“But now we’ve got a child who’s really, really well established in their family at the age of 26 months who’s been with them for the last 14 months whereas being a bit more cautious with respect to the process and thinking ‘oh we’ll wait until all the processes are done before moving him’ would have meant that he’d been in foster care all that time and then basically moving on and going through a disruption, a loss again” (SW1)

Working with individual children and families, participants described holding an awareness of the uniqueness of each permanency case and the need to use a person-centred approach. The role of ‘responsiveness’ was noted in interviews around responding to such work where there is ‘no template’. Each new case had the potential to create twists and turns to which the worker responded and made room for in permanency planning:

“...because no two cases are quite the same, there’s no template...it often feels that a worker is starting again and asking a new set of questions every time they’re working on a permanency case” (SW6)

4.2.7 Recommending

Interviews relayed the process of making recommendations for permanency within lengthy reports. Reports were described as key in collating and integrating information as evidence for the permanency system to consider in their decision making. Alongside emphasising parental and family factors and capacity for change, evidence presented in permanency reports regarding the child’s experiences were discussed in ways consistent with a sense of workers seeking to give voice to the child’s ‘story’:

“Our reports are really important. That’s how we communicate. We take the child’s story and put it in a report saying what he needs” (SW6)

The child’s ‘story’ written in permanency reports was conveyed as providing a means to focus on his holistic developmental experience and psychological and emotional impacts, past, current and future. Workers sought to report direct and indirect factors or ‘damage’ the child had experienced across domains that can be ‘seen or not’:

“We don’t make decisions, we make recommendations. In the reports we present the assessments and evidence of how what this child has experienced is not good enough to meet his needs and how these experiences have left their mark whether that is something that can be seen or not” (SW8)

4.3 Development of the grounded theory: Theoretical coding

The emergent theory developed workers’ descriptions of the central process of holding a child’s experience (his past, current, and future ‘mind in mind’) at the fore within permanency planning while also negotiating the challenges of person-centred working within a multi-agency system. This process contributed to developing evidential strength for permanency planning and was vulnerable to the destabilizing effects of factors related to the emotional demands and system stressors perceived within the permanency role. Early decisions regarding placements and contacts and decisive moves to recommend permanency in reports were responsive to this process and to the complexities of interpersonal working and to hypothetical futures held for the child and for decision makers.

Following selective coding, memoing and constant comparison, theoretical coding referring to psychological theory drew a parallel between the emergent central process of holding the child’s ‘mind in mind’ and ‘mentalization theory’ (Fonagy, Steele, Steele, Moran and Higget, 1991a). Informed by attachment theory (Bowlby, 1969)

‘mentalization’ can be understood as the process of holding another individual’s ‘mind in mind’ in relationships and seeking to understand the mental states (e.g. needs, feelings) behind behaviour. An individual’s capacity to maintain this psychological process is thought to be sensitive to interpersonal context and emotional arousal (Allen, Bleiberg, & Haslam-Hopwood, 2014).

Applied in its broadest sense it seemed that in permanency planning social workers were ‘mentalizing’ the child’s experience when they described emotional and psychological domains of the child’s past, current and future developmental experience. This was seen in interviews around evidential strength and of ‘focus’ on the child which were associated with descriptions of ‘stepping into the child’s shoes’ emotionally when interpreting actual and potential future experiences. At the same time, factors identified as emotionally or interpersonally demanding, or stressful from an organisational perspective were perceived to have a negative impact on this sense of focus on the child’s experiences for workers and for the wider system.

5. Discussion

5.1 Limitations

The substantive theory derived from analysis of interviews with a small sample of eight social workers serves as a preliminary model. Given the small scale of the research it may be that refinement of theoretical categories and subcategories and the GTM concepts of theoretical sampling and saturation may have been improved with further interviews. Further, the sample relied upon volunteer participants who were aware of the researcher’s professional link with the clinical psychologist who was embedded within the practice team introducing issues of selection and reporting bias. Workers who have used the psychologist’s services may have been more likely to take part, with potential implications for the psychologically oriented content of interviews. The study recruited participants based in a single practice team. The capacity to consider whether

the identified categories might be produced similarly within different permanency practice contexts is limited therefore and pertinent bearing in mind evidence regarding locality-based practice in Scotland. Further, although highlighting reflexivity, the researcher is aware that her research and therapeutic background have inevitably coloured the lens through which the data were interpreted. As such the proposed model should be considered as preliminary and be subject to further evaluation. Acknowledging the limitations of the study, the preliminary grounded theory and the central psychological process of mentalization may yet provide tentative suggestions for supports for social workers and progression of permanency cases.

5.2 Integration of findings with the existing literature and implications for practice

The wider literature in the area of child protection and permanency has described a process whereby becoming overwhelmed by work and role pressures (Brown and Ward, 2013) and by parents' difficulties inhibits the capacity to "see the situation clearly, and, in particular, the child's unmet needs" within decision making (Davis & Ward, 2011, p9). Qualitative findings from Kettle (2013) have described social workers' constructions of 'losing the child' within the transaction between interactions with parents and general child protection decision making. Similarly, the Scottish Government's CELCIS programme has used the language of 'lost' to describe the potential for the child's experience to be overwhelmed by the complexity of factors considered within permanency decision making (Davidson, 2017). At the same time, the evidence has suggested that significant delays occur at the early stages of decision making and via delays attributed to a lack of decisive actions (SCRA 2011, 2015; Ward, Brown and Westlake, 2012).

By referring to mentalization theory, the current study has suggested a psychological process emergent from participants' descriptions that is resonant with these descriptions of 'not seeing' the child. The study proposed that 'losing' or 'not seeing' may reflect an,

at times, reduced capacity to ‘stay with’ the child’s mentalized experience in the face of a complex, interpersonally and emotionally overwhelming role that is carried out in the context of a stressed and stressful system. When study interviews described losing focus on the child’s experience this was associated with examples or perceptions of permanency planning becoming stuck or delayed. In discussing interactions with Children’s Hearings and Court systems, the study interviews conveyed workers’ perceptions that similar processes occurred across professional roles within the permanency system.

Recommendations for reducing drift and delay in permanency planning have discussed the use of structured professional judgement (Barlow, Fisher & Jones, 2012), information-management (Kirkman & Melrose, 2014), and performance-monitoring (SCRA, 2015) of permanence processes. Further efforts have focussed on time-bound intensive assessment and systemic intervention (e.g. Family Drug and Alcohol Court, FDAC, Harwin, Alrouh, Ryan & Tunnard, 2014; Glasgow Infant and Family Team intervention, GIFT, Turner-Halliday, Watson & Minnis, 2016).

Inherent within these approaches are decision making processes. In child protection, Baumann, Dalglish, Fluke & Kern (2011) and Munro (2005) have drawn on the wider decision making literature and systems focussed approaches to understand sources of ‘human error’ in decision making. Considered compatible, the models have described decision making as dependent on the interplay between case, organizational, external, and decision maker factors (Baumann *et al*, 2011), and factors relating to the individual, to resources and constraints, and to organizational contexts (Munro, 2005).

While workers did describe organisational factors in interviews, the study evolved to explore workers’ meaning-making around times when ‘focus’ on the child was maintained or lost and theorised around the capacity to maintain mentalization regarding the child’s experience in this respect. As such the current findings appeared compatible

within these models as a ‘decision maker factor’ (Baumann, Dalgleish, Fluke & Kern, 2011) or a ‘factor in the individual’ (Munro, 2005). In particular, Munro’s model considers burnout as a consequence of the emotional and relational impact for individuals working in child protection, associating this with cognitive and emotional distancing from children (p385, Munro, 2005). It may be that the proposed psychological process of mentalization offers a theoretical framework to better understand this individual factor. Supports for workers in areas where they experienced ‘pulls’ on holding the child’s ‘mind in mind’ may be of use to explore further, therefore, and these are now considered within the parameters of mentalization theory.

The capacity to mentalize effectively is thought to fluctuate according to emotional and interpersonal context and is moderated by an individual’s own developmental experiences (Allen, Bleiberg & Haslam-Hopwood, 2014). The wider literature on child protection social work frequently references workers’ experiences of trauma (Horwitz, 2006) or vicarious trauma (Conrad & Kellar-Guenther, 2006; NSPCC, 2013) and workers in the current study described emotionally difficult processes in line with this. Individual variation exists in the likelihood that mentalizing might remain robust in the face of such an emotionally demanding role. Alternatively, mentalization may be more limited and require further support for some individuals even within a relatively supportive system.

Social work practice is inherently interpersonal (Seabury, Seabury, & Garvin, 2011) and the current interviews described the effects of interpersonal complexity on holding the child’s ‘mind in mind’. In their review of safeguarding services Davis and Ward (2011) underlined the necessity for social workers to deliver honest communication within difficult interpersonal contexts. Kedell (2011) has described the value social workers themselves place on maintaining relationships with birth parents in the context of balancing risks and child protection. At the same time, birth parents involved in child protection are reported to perceive the system as ‘dehumanizing’ (Dale, 2004),

presenting with high levels of distress and shame (Gibson, 2015). Emotionally laden interactions with birth parents typify work in this area in which feelings of anger, shame and fear, and contradictory beliefs abound (Schofield and Ward, 2011). Adding to this complex picture, Adshead (2015), drawing on evidence from retrospective research designs has estimated that 60-70% of maltreating parents may be identified as living with a personality disorder or complex emotional needs. Notwithstanding limitations around sampling bias and post hoc reasoning identified in the literature in this area, it may be that parents living with complex emotional needs may be overrepresented within permanency caseloads.

Participants' observations that interpersonal dynamics of birth parents affected permanency decision-making proceedings at the Children's Hearings Panel, appeared consistent with qualitative findings described within recent data published by SCRA (2015a). Designed to document current timescales for permanency proceedings, the report detailed quantitative data indicating that a third of Hearings were continued before a substantive decision was made and asserted that this contributed to permanency delays. Narrative excerpts from social workers taking part in the SCRA study appeared to corroborate the current study's interpretations of 'pulls' on focus away from the child in this context:

"it can take a long time in their involvement with a family for a social worker to 'pull out' of feeling sympathetic to birth parents and/or giving them chances to change their behaviour, and that Children's Panel Members need to be more aware of this" (SCRA, 2015a, p79).

Further research to explore the proposed model within other locations and professional groups is required, of course. However, the current paper suggests tentative implications regarding supports to understand and manage these relational complexities inherent to permanency planning. For example, supporting the emotional management of

interpersonal complexity in reflective supervision may facilitate awareness of such ‘pulls’ away from a child ‘focus’. Indeed, the need to “reclaim high quality clinical supervision” as distinct from case management is identified in practice documents for child protection social workers (Broadhurst, White, Fish, Munro, Fletcher, Lincoln, 2010) and is similarly described in Munro’s model of child protection decision making (Munro, 2005). The current findings suggest that this may be especially helpful for permanency workers. Further, increasing awareness, knowledge and confidence in working interpersonally with parents presenting with complex emotional needs and facilitating ‘shame reducing practice’ (Gibson, 2015) may represent useful interventions *across* professional groups in this respect. For example, it is of note that the FDAC approach has been shown to have reduced delays where permanency outside the birth family was indicated (Harwin, Alrouh, Ryan & Tunnard, 2014). One factor identified by the authors in this respect included consistency of the residing judge throughout proceedings, an approach congruent with managing interpersonal complexity. It may be that similar methods could be beneficial in Scotland.

Drawing on attachment theory, the current study also noted the role of loss in social workers’ accounts of permanency planning. Workers voiced cognitions that suggested they held a sense of personal responsibility for the losses of the child, birth parents and adopters in addition to a sense of loss of professional identity in their role as ‘supporters’ of change, and that this had potential to impact on ‘focus’ on the child. In their review of permanency decision making and children’s timescales Brown and Ward (2012) acknowledged this difficulty for social workers, stating that working effectively in this area “may require professionals to set aside much of the culture of their training and practice” (p72).

Supports for workers to maintain mentalization on the child’s experience in the face of emotional and interpersonal complexity and when attachment systems are activated amid the layered narratives of loss in permanency work may be useful therefore.

Broadhurst *et al.*, (2015), for example, have recently described interventions such as the Pause project (www.pause.org.uk) that seek to work intensively with birth parents who have had children removed to end the cycle of repeat care proceedings in England. It may be that supports such as these might enable workers to experience permanency decision making less as a process of finality for the parent and more as aiding lasting change for both child and parent. In relation to the current grounded theory, reducing the emotional impact of participating in ‘loss making’ may facilitate maintaining mentalization of the child’s experience in permanency decision making. For workers in the current study being ‘new to permanency’ appeared to interact with this process and participants noted that a system of induction by shadowing experienced workers may a beneficial intervention.

Issues around contact decision making were described within the current model as workers described perceptions of the impact of uncertainty and loss on decision makers’ focus on the child. Maintaining contact between children who are separated from their birth families has been documented as a key concern across legal, practice, and lay (Children’s Hearing Panel) decision-makers in Scotland (CELCIS, 2016). Contact decisions balance parental rights alongside awareness of a child’s development and needs, and continual attention to the purpose of contact is crucial at all stages of permanency planning (Humphreys and Kiraly, 2010). The literature documents the task for permanency social workers and decision makers to focus on the child’s current and future needs around contact (Boddy, Statham, Danielsen, Geurts, Join-Lambert and Euillet, 2013; Neil, Beek & Ward, 2015). In a review of research and practice literature on contact in Scotland, Wassell (2013, cited in City of Edinburgh Council, *Keeping in Touch*, 2014) has described social workers’ concerns regarding decision-makers’ understanding of the function of contact, difficulties conveying rational for reducing or stopping contact, and conclusions regarding the application of law in this context, in line with the current findings. Considering the current modelled processes of maintaining and losing focus on the child it seems that further research with decision makers

regarding their sense making around contact in the context of permanency cases may be a useful future direction.

Mentalization is compromised by high emotional arousal (Allen and Fonagy, 2006) and experience of stress is a common theme in child protection social work (Saltiel, 2015). A systematic review of sixty-five studies describing burnout (McFadden, Campbell & Taylor, 2015) in child protection social work has referenced contributory themes including: workload, access to social support and supervision, organizational culture and climate, organizational and professional commitment, and job dissatisfaction. Further, Russ, Lonne and Darlington, (2009) reported the negative impact of work stress, burnout, trauma and vicarious traumatising for child protection social workers. In light of this it is unsurprising that workers in the current study reported stress in the context of permanency social work. However, the interviews suggested that ‘system stressors’ in this context were linked with descriptions of the effects of stress on efforts to focus on the child’s experience when interacting with decision makers. In particular, the findings described the workers’ sense of role in representing the child’s experience to the permanency system in interaction with a sense of stress associated with perceptions of professional hierarchy, feeling undermined and held in low esteem by, and, at times, in conflict with, the legal system.

Perceptions of a professional hierarchy appeared to reflect a general perception reported by social workers (Smith, 2009). Similar themes of ‘status and power’ for workers practicing in multidisciplinary teams (Frost, Robinson and Anning, 2005) and of ‘strength of voice’ relative to other professionals (O’Connor and Leonard, 2014) have been documented generally and for child protection workers. In the context of permanency, the current findings regarding feeling undermined appeared to echo SCRA focus group reports (SCRA 2015a) which also described perceptions of negative impacts on social workers’ morale when Children’s Hearings members question, seek ‘expert’ opinion, or do not understand recommendations. A similar experience was voiced by

Turner-Halliday, Watson and Minnis (2016) in their thematic analysis of the experiences of permanency social workers participating in an intervention trial. In that study participants spoke of other professionals reiterating or repeating social workers' evidencing which could also 'add weight' to evidence. Workers variously perceived this as helpful or as undermining. The current study's participants were clear that, for permanency work, challenges around hierarchy extended beyond the Hearings system to Court.

The findings may point generally, therefore, towards a 'professional empathy' approach that facilitates a greater understanding across professionals. Consistent with this, recommendations by SCRA (2015) suggest raising Children's Hearings Panel members' awareness of the level of skill and prior scrutiny of permanency recommendations. Similarly, in their recent outline of work to date in efforts to improve outcomes for children involved in permanency proceedings, the Scottish Government's Permanence and Care Excellence programme has stated that preliminary professional interventions in this area have been "revelatory for some" (PACE; CELCIS, 2016, p9). A useful extension from the current findings might be to widen this approach to include the legal profession. The current theory proposes that reducing the emotional demands associated with the wider permanency system may facilitate workers to focus on holding and representing the child's experience.

Finally, mentalization is a modifiable skill (Allen & Fonagy, 2006). The research around child protection decision making cites low levels of training in child development as a practice-related factor associated with delays particularly for young infants (Ward, Brown, Westlake and Munro, 2012; Wassell, 2013). It may be that training in models of infant state regulation and interpretation of the expression of regulatory behaviours as communication of internal experiences may provide workers with a framework to mentalize the young infant's experience alongside consideration of parental factors. Additional mentalization-consistent approaches that may support

formal decision-making tools regarding permanency might include the use of photographs of the child on case notes and illustrated, visual time-lines of development alongside critical experiences (Davidson, 2017).

6. Conclusion

Notwithstanding limitations, this in-depth, qualitative study draws attention to the psychological process of mentalization to facilitate ‘focus’ on the child in permanency planning. In doing so it suggests the need to support the emotional wellbeing and reflective capacity of social workers working in this complex, interpersonally, and emotionally demanding field to promote effective permanency working. This may involve a number of factors including increasing the use of specialist training in infant development, intensive, therapeutic support for birth parents following permanency proceedings, access to reflective, clinical supervision, work to increase professional empathy, and system-wide access to specialist training in working with individuals with complex emotional needs.

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Journal Article 2: Systematic Review

Title

Experience of childhood maltreatment and reflective function of parents: A systematic review of observational research findings

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Abstract

This review considers childhood experiences of maltreatment (CM) in relation to adult reflective function (RF) in parenting, a variable implicated in infant attachment security. A systematic search of the literature identified seven datasets (of which nine papers) presenting analyses relating to measurement of childhood maltreatment and parents' RF. Although the identified studies indicated a lack of significant association between the factors, critical evaluation of conceptual, methodological and population issues indicated that the small number of reviewed papers were limited in their capacity to address the review question. After further data reduction according to study quality and separation of analyses according to conceptualisation of mentalization there remained two datasets reporting on CM and adult RF, and three reporting analyses of CM and parenting RF. Conceptual differences regarding mentalization and RF are considered in relation to emerging areas of research in this field.

Key Words: Mentalizing, reflective function, childhood maltreatment, parenting

Conflicts of interest: No known conflicts.

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1. Introduction

Developing a secure attachment relationship with a caregiver in infancy has been linked to positive outcomes across the lifespan (Sroufe, 2005). The promotion of secure attachment and the identification of factors which foster or impair this relationship have, therefore, been the focus of much clinical and research attention. Interpersonal communicative connections between carers and infants are thought to be formative experiences within which attachment relationships develop (Lyons-Ruth, 2008). In this dynamic, dyadic process the unfolding of a relationship towards attachment security may be threatened by factors affecting either partner's capacity for attuned responsiveness.

The capacity to parent competently has been described as “a critical test of adult development” (Fonagy, Steele, Steele, Higgitt, & Target, 1994, p233) and attuned parenting can be affected by many factors including mental health (Marryat & Martin, 2010), psychosocial adversity (Murray, Fiori-Cowley, Hooper, & Cooper, 1996) and internalized models of parenting developed in the early years (Fonagy *et al.*, 1994). Experiences of childhood maltreatment (CM) are a well documented adversity factor regarding psychosocial outcomes in adulthood (Edwards, Holden, Felitti, & Anda, 2003) and the literature suggests a link between maltreatment history and parenting outcomes (Bailey, DeOliveira, Wolfe, Evans, & Hartwick, 2012; Caldwell, Shaver, Li, & Minzenberg, 2011).

1.1 Psychological processes and parenting behaviours: Mentalization and Reflective Function

In order to better understand how the effects of limited internal and external resources affect parenting, research has focused on the underlying psychological processes that may mediate parental behaviours. The capacity to assign agency to an infant, to enter into a reflective consideration of his inner experiences as a motivator for behaviour and take a ‘mentalizing’ stance to his and one's own position, is one such process (Fonagy,

Steele, Steele, Moran, & Higgit, 1991a). It has been suggested that this process of mentalization during mother-infant communication, rather than a more global ‘sensitivity’ to infant cues, is more predictive of later infant attachment security (Meins, Ferryhough, Fradley, & Tuckey, 2001).

Stemming from the psychoanalytic concepts of mentalization and attachment theory, reflective function (RF) can be thought of as “the operationalization of the mental processes that underpin the capacity to mentalize” (Katznelson, 2014, p108) or “mentalization measured in the context of attachment” (Fonagy & Target, 2005, p334). In this way, measures of RF are thought to capture our capacity for ‘mentalizing’ when we demonstrate the relationship-based, human capacity of seeking to understand and attribute mental state explanations of our own and others’ behaviour. Fonagy, Gergely, Jurist, & Target (2002) describe these processes as our implicit (at the level of non-verbal communication behaviours, for example) or explicit (at a cognitive level) awareness of the underlying motivation of needs, desires, feelings, beliefs, goals, purposes and reasons beneath our own and others’ behavioural acts.

Mentalization and RF are considered as crucial for emotional regulation and difficulties in this area are thought to be implicated in the development of personality disorders (Bateman & Fonagy, 2010). Parenting that promotes a secure attachment relationship also provides an infant with the parent’s attuned feedback to integrate his emotional experiences. Via this process an infant is supported to move developmentally towards an ability to independently reflect upon and understand his/her own mental states. Developing an effective, flexible mentalizing capacity is associated with a coherent sense of identity and social self-other awareness that is responsive to situational factors leading, thereby, to healthy interpersonal relationships.

The seminal research of Fonagy, Steele, & Steele (1991b) evidencing a predictive relationship between prenatally assessed maternal RF regarding mothers’ own

attachment relationships and later infant attachment style, has now reached its 25th year since publication. In this time, the parenting literature has reported variously on the role of RF in facilitating parenting behaviours congruent with, or buffering against parenting behaviours which negatively affect, the development of secure attachment relationships for infants (Grienenberger, Kelly, & Slade 2005; Katznelson, 2014; Slade, Grienenberger, Bernbach, Levy, & Locker, 2005).

Parental risk factors and their effect on RF have also been explored (Smaling *et al.*, 2016). The parent's psychosocial context can affect both RF that facilitates attribution of meaning to infant behaviours and the capacity to reflect on the feelings aroused by becoming a parent and how these affect parenting behaviours (Suchman, Pajulo, Kalland, DeCoste, & Mayes, 2012). Findings in this area emphasize the significance of facilitating RF when working clinically with parents and infants, especially where relationships are developing within environments characterised by higher psychosocial stress. Consequently, clinical interventions designed to promote parenting mentalization and RF have been developed for 'at risk' populations, of which parents who have experienced CM tend to be overrepresented (Ordway, *et al.*, 2014; Sadler, Slade, & Mayes, 2006). The extent to which experience of CM itself is a risk factor in terms of parenting RF, however, is unclear and has been described as an area in need of research attention (Pajulo *et al.*, 2012).

2. Review question

With this in mind, the current review aims to synthesise the existing literature to explore the review question: what is the association between parental CM and reflective functioning in parenting?

3. Method

3.1 Systematic review protocol

Centre for Reviews and Dissemination (CRD, 2009) guidance was utilised to specify in advance a review protocol. The review question, scope, and methods were outlined including definitions of the population, exposure and outcomes of interest. The protocol further included identified study designs, the search strategy, data extraction, quality assessment, data synthesis and plans for dissemination (Appendix 9).

3.2 Search strategy

The literature search was conducted in February 2016 to identify empirical articles from 1991 onwards (year of onset: when the role of mentalizing first appeared in the literature (Macintosh, 2013)). In consultation with an academic support librarian at the University of Edinburgh the following databases were accessed: MEDLINE; PsycINFO; Embase; Applied Social Sciences Index (ASSIA); Education Resources Information Centre (ERIC); Social Services Abstracts; Published International Literature on Traumatic Stress (PILOTS). The search was limited to English Language publications and human participants applying the terminology: (Trauma* OR Abus* OR Maltreat* OR Neglect* OR “adverse childhood experience*” OR PTSD OR “early life stress”) AND (Mentalis* OR Mentaliz* OR “Reflective func*” OR “mind minded*” OR mindminded* OR “mothers insightfulness” OR “maternal insightfulness”) AND (Parent* OR Carer* OR Caregiv* OR Mother* OR Father* OR “care giver*”).

3.3 Inclusion criteria

After piloting of the selection process citations were included for further review if they appeared relevant and met inclusion criteria (Table 1). Reference sections were hand searched where relevant. No restrictions were applied regarding parental mental health status or lifestyle factors; instead these will be discussed in the research synthesis. Study quality was not utilised as an exclusion criterion but was considered in discussion of the findings.

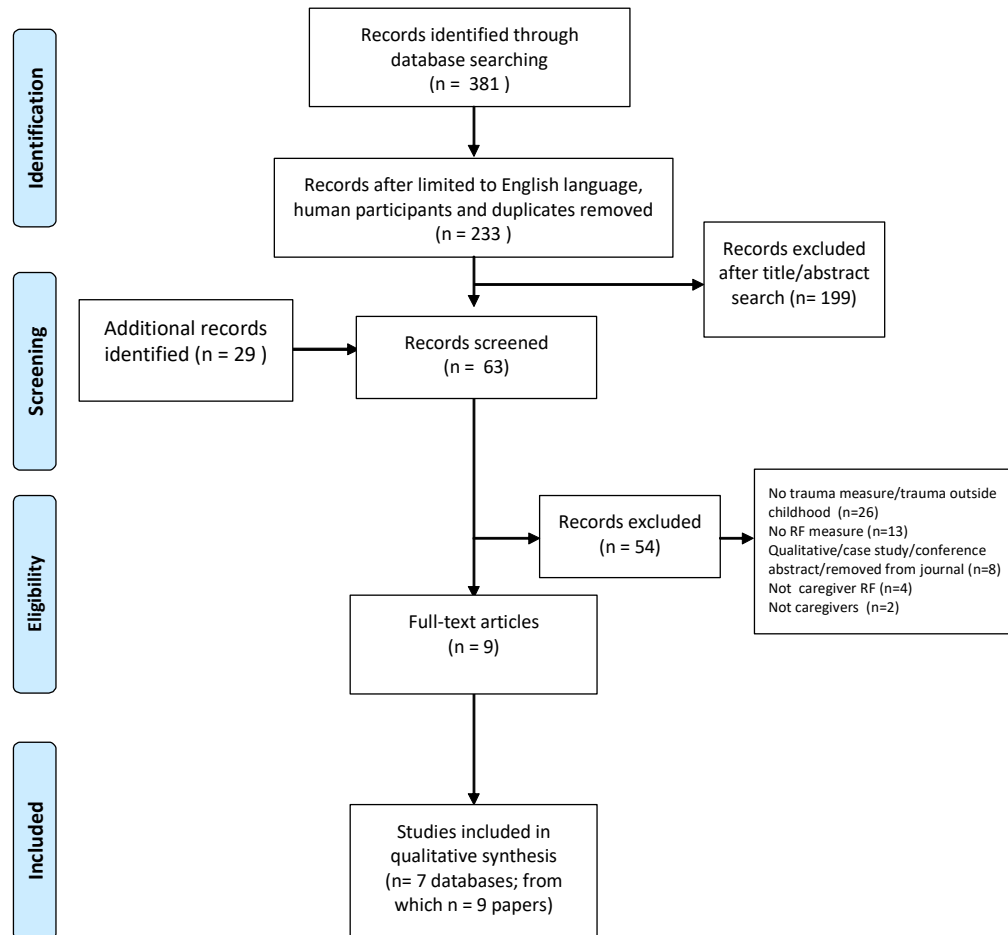
Table 1: Inclusion/exclusion criteria

	Included	Excluded
Publication type	Peer reviewed journal articles, unpublished research dissertations	Conference abstracts, book reviews, book chapters
Study design	RCT's, cohort, cross-sectional, before and after treatment	Qualitative, case series, case reports
Language	English	Non-english
CM	Measure of parent's experience of emotional, physical, and sexual neglect/abuse up to and including age 18	CM beyond age 18 years
RF	Measure of RF in relation to parenting	RF not in relation to parenting
Participants	Primary caregivers with measures of CM and RF	Non-caregivers. Primary caregivers without measures of both CM and RF

4. Search results

An initial search identified 381 publications. Search strategy and results are described in Figure 1 (based on the PRISMA template; Moher, Liberati, Tetzlaff, & Altman, 2009). This search of systematic review databases and of Google Scholar indicated that the current review was not likely to duplicate existing information available in the public domain. Fifty-three papers were excluded following abstract/full-text review (see Appendix 10).

Figure 1: Search strategy



5. Results of the review

5.1 Main characteristics of the identified studies

The main characteristics of the seven source datasets (nine studies) are presented by date/dataset order (Table 2). Published between 1994 and 2016, all nine studies were classified as observational in design and comprised six prospective, longitudinal cohort studies, one cross sectional cohort and one cross sectional study, and one before and after treatment design. The studies were of exclusively Western populations including Australia, Canada, Finland, the United Kingdom and the USA. Participants included

mothers in eight studies and fathers in one and were drawn from community samples, substance misuse populations and CM samples. Sample sizes ranged from 26 to 115 participants (total 771; after attrition of participants in longitudinal studies $n = 670$, range = 17-115). Examination of the participants included in analyses of the association between CM and caregiver RF indicated a combined figure of $n = 561^*$. Four studies investigated Adult RF (mothers' reflective function regarding their own attachment relationships) and five assessed Parental RF (reflective function regarding the child).

*only participants with complete measures for CM and caregiver RF, and utilising the larger n where studies report on the same original dataset.

Table 2: Summary of included studies

Authors	Aim	Population/ Study design	Method	Maltreatment / RF measures	Trauma-RF analysis/results
1. Fonagy, Steele, Steele, Higgitt, & Target (1994). *study details from Fonagy <i>et al.</i> , (1991 a, b)	Development of theory around transgenerational resilience, exploring the role of RF as a protective factor for mothers with adverse histories.	n=100 women (n=96 retained to follow-up), United Kingdom. Prospective, longitudinal cohort	Semi structured interviews: 3rd trimester- AAI; Observed mother-infant attachment relationship: 12-13 months- SSP; 12-13 months-life events /difficulties (“hardship index”; p241) and transition to parenthood interviews.	Maltreatment: Manualized criteria identified individuals scoring in the top 33% for AAI transcripts on at least 2 of the ‘Probable Experience’ scales: ‘least loving’, ‘rejection’ and ‘neglect’ comprised a “deprived childhood” group (p240). Adult RF: “Reflective Self Function” derived from RF scale (Fonagy <i>et al.</i> , 1991) applied to AAI transcripts.	No direct analysis of experience of CM and RF reported. Significant 3-way interaction between ‘childhood deprivation’ Adult RF and infant attachment security (likelihood ratio $\chi^2(1)=10.61$, $p<0.001$) whereby childhood deprivation and high Adult RF were associated with infant attachment security.
2. Pajulo, Pyykkönen, Kalland, Sinkkonen, Helenius, Punamäki, & Suchman (2012)	To explore, among high-risk substance misusing mother-infant pairs, the role of RF as a mediating mechanism for response to treatment including analysis of factors related to pre- and postnatal RF levels.	45 mothers in treatment for substance misuse (34 retained at follow-up). Finland. Before and after treatment study.	<i>Pregnancy</i> -questionnaires: demographics, pregnancy history, delivery, substance use/treatment history, substance use / treatment contacts, child somatic symptoms, mother’s living situation/child placement; <i>3 months</i> -questionnaires: EPDS; <i>4 months</i> -parenting behaviour: CI, child development: BSID-II.	1 year maltreatment questionnaire: TAC (initial n=?) Parental RF (pregnancy): PI (n=19) Parental RF (postnatal) - 4 months: PDI (n=29)	Correlational statistics of the association between CM and Parental RF referred to but not reported suggest a non-significant association (“marginally significantly associated” p76). Greater exposure to ‘family secrets’ in childhood was related to less positive change in RF during substance misuse intervention ($n=16$), $r=-0.77$, $p=0.01$). Similar non-significant correlation for physical abuse ($r=-0.53$, $p=0.07$).

3. Stover & Kiselica (2014)	To examine factors associated with RF in fathers; to determine if RF was associated with fathers' self-reported parenting behaviours	N=42 fathers of IPV and/or substance abuse; n= 37 community controls. USA. Cross sectional cohort study	Self-report questionnaires: ECR-R, CTS2, PARQ, PRQ, BSI. Structured interview: ASI	Maltreatment questionnaire administered in interview format: CTQ Parental RF (re. index child, range 2-6 years): PDI-R	the source paper for the data base (Stover <i>et al.</i> ,2013) stated that IPV/SA group did not differ from the community comparison group in terms of exposure to trauma in childhood. Correlational analysis of total CTQ scores for the overall sample indicates no significant association with PDI-R scores ($r=0.06$, ns).
4. Huth-Bocks, Muzik, Beeghly, Earls, & Stacks (2014).	To evaluate the association between maternal secure base attachment scripts (total, parent-child or romantic), parenting behaviours across 'low-demand' and 'high demand' contexts, and RF.	N=115 mothers oversampled for CM. MACY study, USA. Prospective, longitudinal cohort study	4 months self-report questionnaires: National Women's Study PTSD Module; 7 month questionnaires: Demographic risks, child and family functioning; 16 month interview: ASA; 16 month observed parenting quality: MIPCS	Maltreatment-4 months questionnaire (by phone interview): CTQ Parental R-F -16 months: PDI-R2-S	No significant correlational association between CM history and RF (r value not reported)
5. Stacks, Muzik, Wong, Beeghly, Huth-Bocks, Irwin, & Rosenblum (2014)	To examine relationships between RF, parenting, and infant attachment and associations with psychosocial and demographic risks. To determine whether observed parenting quality mediated the association between RF and infant attachment.	n=83 mothers oversampled for CM. MACY study, USA. Prospective, longitudinal cohort study.	7 month self-report questionnaires: Demographic risks. 16 month interviews: PPDS, National Women's Study PTSD Module; 16 month observed parenting quality: MIPCS; 16 month observed infant attachment relationship: SSP.	Maltreatment-4 months questionnaire (by phone interview): CTQ Parental R-F- 16 months: PDI-R2-S	No significant correlational association between CM history and RF ($r=-0.05$, NS).

6. Perry, Newman, Hunter, & Dunlop (2015)	To investigate 1) the associations between psychosocial/demographic risks for mothers currently in treatment for substance misuse and antenatal/postnatal RF; and 2) the impact of current psychosocial stress, past and current trauma, current mental health problems on maternal RF and its mediating role in child protection involvement.	N=11 mothers in methadone maintenance treatment vs. 15 comparison mothers. Outcome measures n=5 index and 12 comparison. Australia. Prospective, longitudinal cohort study	3 rd trimester self-report questionnaires: EPDS, NDKQ; 3 rd trimester interviews: Psychosocial Assessment Interview, ZAN-BPD; 3-20 month observed parenting behaviours: EAS; 3-20 month assessment of child protection involvement: accessed via child protection records.	<i>Maltreatment</i> - 3 rd trimester questionnaire: CTQ; <i>Parental RF (pregnancy)</i> - 3 rd trimester: PI-R; <i>Parental RF (postnatal)</i> 3-20 month: PDI	Antenatal (n=26) and postnatal (n=17) RF not significantly correlated with CM history (r not reported).
7. Ensink, Berthelot, Bernazzani, Normandin, & Fonagy (2014)	To explore Adult RF of pregnant women with CM histories comparing General RF and Trauma-specific RF in a community sample.	Community sample of N=100 pregnant women with histories of CM. Canada. Cross-sectional study.	Questionnaire: PBI; Interviews: AAI, CAME	<i>Maltreatment</i> - 3 rd trimester, interview: CECA (n=97). <i>Adult RF</i> : The AAI was coded for RF, using the RF manual (Fonagy <i>et al.</i> , 1998). RF regarding Traumatic Experiences: assessed using the RF-T scale applied to AAI transcripts (devised for paper)	Paired t-tests indicated RF-T scores were significantly lower than RF-G scores test ($t(63) = 4.93, p < 0.001, d = 0.70$), No association shown in a linear regression between dose of maltreatment and RF-G ($\beta = -0.04, t(55) = -0.43, p = 0.67$) or RF-T ($\beta = -0.07, t(35) = 0.48, p = 0.64$).

8. Berthelot, Ensink, Bernazzani, Normandin, Luyten, Fonagy (2015)	20 month longitudinal follow-up study of Ensink <i>et al.</i> , (2014) to explore the predictive relationship between RF regarding mothers' experience of CM, maternal attachment states of mind and infant attachment disorganization.	N=57 (of original n=100) women with histories of CM. Community sample. Canada. Prospective, longitudinal cohort study	3rd trimester screening questionnaire: PBI; 3rd trimester interview: AAI; 17 months observed infant attachment relationship: SSP.	<i>Maltreatment</i> - 3rd trimester, interview: CECA <i>Adult RF</i> - 3rd trimester, interview: The AAI was coded for RF, using the RF manual (Fonagy <i>et al.</i> , 1998). RF regarding Traumatic Experiences - 3rd trimester: assessed using the RF-T scale applied to AAI transcripts (devised for paper)	Dose-response analysis did not find a relationship between dose of CM and, the level of mothers' RF-T, $\beta = .07$, $t(35) = 0.48$, $p = 0.64$, RF-G, $\beta = -0.04$, $t(55) = -0.43$, $p = 0.67$, Mothers with histories of childhood abuse and low RF-T were 3.43 times more likely to have infants with attachment disorganization than were mothers with trauma histories and high RF-T.
9. Ensink, Normandin, Plamondon, Berthelot, Fonagy, Roberts, William, . . . Tarabulsky (2016)	To examine the relationships and pathways between Adult RF, parenting behaviours, and infant attachment outcomes.	n=88 women screened to include 30% with experiences of maltreatment in childhood. Canada. Prospective, longitudinal cohort study	3rd trimester interview: AAI; 6 months observed parenting behaviour: the Sensitivity Scale; 16 months observed infant attachment relationship: SSP; 16 months observed parenting behaviour: DIP	Maltreatment - 3rd trimester, interview: assessed via mothers' reports of abuse during the AAI. <i>Adult RF</i> - 3rd trimester, interview: AAI transcripts coded for RF using the RF manual (Fonagy <i>et al.</i> , 1998).	No significant correlation between maltreatment history and Adult RF ($r = -0.14$, ns)

AAI : Adult Attachment Interview (George *et al.*, 1985); ASA: Attachment Script Assessment (Waters & Rodrigue-Doolabh, 2001, 2004); ASI: Addiction Severity Index (5th ed.) (McLellan *et al.*, 1992); BSID-II: Bayley Scales of Infant Development (Bayley, 1993); BSI: Brief Symptom Inventory (Derogatis, 1993); CAME: Contextual Assessment of Maternity Experience (Bernazzani *et al.*, 2005); CI: Care Index (Crittenden, 2003); CECA: Childhood Experience of Care and Abuse (Bifulco *et al.*, 1994); CTQ Childhood Trauma Questionnaire (Bernstein & Fink, 1998); DIP: Disconnected and Insensitive Parenting (Out *et al.*, 2009); EAS: Emotional Availability Scales Biringen, 2008); ECR-R: Experiences in Close Relationships-Revised Questionnaire (Fraley & Waller, 1998); EPDS: Edinburgh Postnatal Depression Scale (Cox 1987); MIPCS: MACY Infant-Parent Coding System (Earls, Muzik, & Beeghly, 2009); National Women's Study PTSD Module (Resnick *et al.*, 1993); NDKQ: Newborn Developmental Knowledge Questionnaire (Newman, 2006); Psychosocial Assessment Interview (Hunter New England Health, 2005); PARQ: The Parental Acceptance and Rejection Questionnaire (Rohner *et al.*, 2005); PBI: The Parental Bonding Instrument (Parker *et al.*, 1979); PDI: Parent Development Interview (Slade *et al.*, 2005); PDI-R: Parent Development Interview-Revised (Slade *et al.*, 2004); PI: Pregnancy Interview (Slade *et al.*, 2004); PI-R: Pregnancy Interview-Revised (Slade *et al.*, 2007); PPDS: Postpartum depression Screening Scale (Beck and Gable, 2000); PRQ: Parenting Relationship Questionnaire (Kamphaus & Reynolds, 2006); RCTS: Revised Conflict Tactics Scale (Straus *et al.*, 1996); SSP: Strange situation procedure (Ainsworth *et al.*, 1978); TAC: Traumatic Antecedents Questionnaire (Van der Kolk, 2003); ZAN-BPD: Zanarini Rating Scale for Borderline Personality Disorder (Zanarini *et al.*, 2003).

5.2 Quality assessment

A tool to assess the quality of included studies was developed drawing on the Scottish Intercollegiate Guidelines Network Methodology Checklist 3: Cohort Studies (SIGN, 2004) and the National Institutes of Health Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies (NIH, 2014; Appendix 11). The tool emphasised assessment of risk of bias and was initially piloted on two papers excluded from the review. Method sections of relevant source papers of identified databases were consulted where necessary. Studies were rated across ten quality criteria and the ability of the study to minimise risk of bias and establish the relationship between exposure and effect was rated as good, fair or poor. Inter-rater agreement between the author and an independent reviewer was analysed for seven database studies across quality items and found to be good (Cohen's Kappa = 0.805). Table 3 summarises the outcome of ratings and overall assessment of study quality.

Table 3: Summary of quality assessment

	Research question	Population Participation Attrition	Sample size	Measures exposure/ outcome	Exposure gradient/ Confounders/ Blinding	Overall quality
Fonagy <i>et al.</i> (1994)	<i>good</i>	<i>poor/poor/good</i>	<i>not addressed</i>	<i>poor/poor</i>	<i>poor/fair/fair</i>	<i>Poor</i>
Pajulo <i>et al.</i> (2012)	<i>good</i>	<i>fair/fair/poor</i>	<i>not addressed</i>	<i>poor/good</i>	<i>poor/fair/good</i>	<i>Fair</i>
Stover & Kiselica (2014)	<i>good</i>	<i>fair/poor/not addressed</i>	<i>fair</i>	<i>good/good</i>	<i>poor/poor/fair</i>	<i>Fair</i>
Huth-Bocks <i>et al.</i> , (2014)	<i>good</i>	<i>fair/fair/good</i>	<i>not addressed</i>	<i>good/good</i>	<i>poor/good/good</i>	<i>Fair</i>
Stacks <i>et al.</i> ,(2014)	<i>good</i>	<i>fair/fair/fair</i>	<i>not addressed</i>	<i>good/good</i>	<i>poor/fair/good</i>	<i>Fair</i>
Perry <i>et al.</i> ,(2015)	<i>fair</i>	<i>fair/poor/poor</i>	<i>not addressed</i>	<i>fair/fair</i>	<i>poor/poor/fair</i>	<i>Poor</i>
Berthelot <i>et al.</i> , (2015)	<i>good</i>	<i>fair/fair/poor</i>	<i>not addressed</i>	<i>fair/good</i>	<i>good/poor/poor</i>	<i>Fair</i>
Ensink <i>et al.</i> ,(2014)	<i>good</i>	<i>fair/fair/not applicable</i>	<i>not addressed</i>	<i>poor/good</i>	<i>good/not addressed/good</i>	<i>Good</i>
Ensink <i>et al.</i> ,(2016)	<i>good</i>	<i>fair/poor/fair</i>	<i>not addressed</i>	<i>fair/fair</i>	<i>not addressed/fair/notaddressed</i>	<i>Fair</i>

6. Main findings

6.1 Childhood maltreatment and caregiver reflective function

Each of the included studies presented analyses relating to CM and caregiver RF. Analyses were noted to fall into categories according to the examination of RF coded from interviews regarding parenting (Parental RF) or RF derived from interviews with caregivers focussing on attachment histories (Adult RF) and this division serves as an organizer for the review's results. The reader is encouraged to refer to Table 2 for full study findings, definition of acronyms and reference papers.

6.2 Parental reflective function

Five papers examined CM and parental RF, four were considered to be of fair quality and Perry *et al.*, 2015 was rated poor.

Stacks *et al.*, (2014) examined CM and Parental RF to explore the impact of demographic and psychosocial risk on RF, observed parenting behaviours and infant attachment relationship outcomes. Findings indicated that while participants' experience of CM was related to PTSD and depression, it was not related to Parental RF ($r = -0.05$, NS).

In a separate analysis, derived from the same dataset, Huth-Bocks *et al.*, (2014) analysed CM and RF data from 43% of individuals from the full sample. The study reported analyses of the relationship between CM and Parental RF within their investigation of maternal attachment scripts and observed positive and negative parenting behaviours at seven and 16-months postnatally. No correlation was found between CM and Parental RF. Although statistics were not definitively reported for these findings the authors write that " r s ranged from .00 to .16, all non-significant" (p545).

Three papers analysed data from participants with substance misuse issues; a group in which experiences of CM tend to be overrepresented (Dube *et al.*, 2003). Two papers studied mothers and one fathers.

Firstly, Pajulo *et al.*, (2012) explored the associations between CM history, psychiatric symptoms, observed parenting quality at 4-months postnatally, later foster care placement and pre- and postnatal Parental RF. The paper reported a non-significant correlation (“marginally significantly associated”; $p=0.07$) between CM measured by the TAQ and RF. Analysing subscales from the CM measure the authors reported that greater exposure to ‘family secrets’ was associated with less positive change in RF during intervention for substance misuse ($n = 16$; $r = -0.77$, $p = .01$).

Stover and Kiselica (2014) represented the only identified paper presenting analyses examining CM and Parental RF with a sample of fathers. The paper explored demographic and psychosocial factors associated with Parental RF and the association between this variable and self-reported parenting behaviours. An earlier publication utilising data from the same sample (Stover, Easton, & MacMahon, 2013) reported that men in the IPV/SA group did not evidence a greater incidence of CM. Correlational analyses of CM and Parental RF scores conducted by Stover and Kiselica (2014) indicated that the factors were not associated ($r = 0.06$, ns) for the combined sample.

Perry *et al.*, (2015) presented data relating to CM and RF within a pilot study designed to develop better detection of need and clinical intervention in the context of substance misuse and to predict child protection involvement postnatally. In relation to the review question, while low risk mothers reported lower rates of CM, the study did not find any association between CM history and ante- or postnatal Parental RF. CM was not associated with observed parenting behaviour or current mental health. Further, ante- and postnatal Parental RF and parenting quality were not found to differ between comparison groups and did not predict child protection involvement.

6.3 Adult reflective function

Four papers identified within this subset reported analyses of the association between CM and RF of caregivers regarding their own attachment experiences (Adult RF), in addition to RF specific to childhood trauma experiences (RF-T), and the impact of

these factors on parenting and child variables. The study by Fonagy *et al.*, (1994) was considered as poor according to the quality ratings tool. Of the remaining three studies, one was rated good and two as fair.

Fonagy *et al.*, (1994) analysed AAI derived Adult RF and infant attachment relationship outcomes for a sample of 100 women and infants. Having previously reported concordance of maternal and infant attachment relationship patterns (Fonagy *et al.*, 1991a) and the development of a tool to assess RF from AAI transcripts (Fonagy *et al.*, 1991b), the group explored the role of RF as a protective factor “for mothers with adverse histories” (p224). In relation to the review question, the as yet unvalidated RF scale was applied to AAI transcripts by coders who also assessed the presence of items related to ‘deprived childhood’; and the interaction of these factors on infant attachment relationships was reported.

Infants of mothers in the ‘deprived childhood’ group were reported to be more likely to have insecure attachment relationship styles at 12-months. Further, Adult RF interacted with this relationship so that deprived mothers scoring higher for this variable were significantly more likely to have securely attached infants relative to deprived mothers with low RF. The authors related their findings to a protective model of resilience whereby the presence of stress accentuates a protective effect for individuals with higher levels of a resilience trait (Adult RF in this case).

Ensink *et al.*, (2014) considered the conceptual work of Fraiberg, Adelson, & Shapiro (1975) and Fonagy (1993) in an exploration of the impact of CM on Adult RF and adjustment to parenting within a sample selected exclusively for childhood maltreatment. Analyses did not detect a relationship between the severity of CM and either a measure of general RF (RF-G) or RF specific to traumatic experiences (RF-T). RF-T scores were significantly lower than RF-G scores for this group (notably, mean RF-G scores were described as only “somewhat lower” than means reported in low-risk populations).

Berthelot *et al.*, (2015) prospectively followed up 59% of this same sample. Regarding the relationship between CM and RF, the study mirrored the findings of Ensink *et al.*, (2014). While dose of maltreatment (number of types of maltreatment) was associated with participants' AAI unresolved attachment status, it was not associated with RF (T or G). The majority of infants for this CM group were found to have insecure attachment relationships and 44% were disorganized. Dose of early maltreatment was not directly associated with infant attachment disorganisation. Furthering the findings of Fonagy *et al.*, (1994) the study reported that infants of mothers with maltreatment histories who showed high RF-T (and not RF-G) were more likely to have organized attachment relationship styles. Infants of low RF-T mothers with abuse histories were 3.43 times more likely to be assessed as showing disorganized attachment. Regression analyses indicated that while both variables contributed independently, RF-T accounted for nearly twice the variance in infant disorganization relative to mothers' AAI unresolved trauma status alone.

Finally, as part of a larger study (unreferenced in the paper) investigating the transition from pregnancy to maternity, Ensink *et al.*, (2016) reported data from a longitudinal cohort of women screened by telephone interview to include 30% who reported histories of CM. With regards to maternal maltreatment history and RF, the study reported no direct association ($r = -0.14$, ns) and maltreatment did not predict in the model when entered as a covariate in path analysis of reflective functioning, parenting and attachment outcomes.

7. Critical appraisal

Of the analyses of CM and RF reported within the nine studies reviewed (seven source datasets) eight conducted direct analyses of the variables and none reported a significant correlation between the variables. Factors affecting confidence in this finding and are discussed below.

7.1 Study quality

Summarised by dataset, quality ratings were: one good/fair, four fair, and two poor. With only one study rated as good, it is difficult to be confident in the validity of the current findings.

Potential for bias or imprecision was apparent within the reviewed studies/datasets for a number of reasons. Firstly, it is important to acknowledge the view that observational research is considered to lack the rigour and reduced risk of bias associated with randomised control trial (RCT) methods. Clearly, direct experimental manipulation and allocation to active/control group status is not possible within this subject area. Intervention studies using RCT designs represent a more acceptable means to test theoretical developments, therefore the exclusively observational research identified herein is at raised risk of selection bias. Further issues include systematic error associated the use of self selection of participants by Stover & Kiselica, (2014) and Ensink *et al.*, (2016) and for an undefined proportion of mothers taking part in Stacks *et al.*, (2014) and Huth-Bocks *et al.*, (2014). Performance bias introduced via lack of blinding of outcome assessors to exposure status was apparent for Fonagy *et al.*, (1994) and Berthelot *et al.*, (2014), and was not clear for Ensink *et al.*, (2016). Bias stemming from attrition affected Perry *et al.*, (2012), Huth-Bocks *et al.*, (2014), and Ensink *et al.*, (2016). Finally, while analyses of three studies were conducted with populations of $n = 100+$ after attrition (Ensink *et al.*, 2014; Ensink *et al.*, 2016; Huth-Bocks *et al.*, 2014), the majority ranged from 16 to 96 (median 79). It is likely, therefore, that imprecision due to sampling variation may affect confidence in findings from these studies.

Further, a number of conceptual, methodological, and population issues within the reviewed studies require careful consideration:

7.2 Conceptual

Following Fonagy *et al.*, (1994), the subsequent eight studies (six datasets) were all published onwards from 2012 highlighting the still nascent state of this research area and, as a theoretical framework, mentalization has been described as perhaps not yet

a “full-fledged” theory (Liljenfors & Lundh, 2015, p37). An individual’s capacity to mentalize is thought to depend on the relationship context as well as levels of emotional arousal. Fonagy & Luyten, (2009) state that “*Mentalization is likely to show considerable fluctuations over time and across relationship contexts, not just as a function of stress but also as a function of the quality of particular relationships*” (p1374). In the same way that an individual may be more or less likely to respond anxiously day-to-day, and at the same time experience fluctuations in anxiety dependent on context, mentalization appears to have state and trait-like qualities. The capacity to mentalize may vary dependent on interpersonal or emotional arousal (state) and at the same time may appear as a more consistent, trait-like factor associated with one’s own developmental experience. Conceptually this raises questions regarding whether it is valid to compare the assessment of RF or mentalizing across the identified datasets.

The papers reviewed were grouped around those assessing RF regarding parents’ own attachment relationships and studies investigating parents’ RF in relation to their infants. RF regarding one’s own parenting experiences may tap in to trait-like mentalization while mentalization in the context of the emotional arousal associated with care-taking may be linked to state-like variation. For the current paper, this suggests that the limited pool of papers identified may be further reduced so that findings lack a robust data set on which to draw conclusions.

7.3 Measurement

7.3.1 Measurement of childhood maltreatment

Measurement of parents’ experiences of CM differed across studies and was variously obtained by interview (CECA or mothers’ reports in the AAI) and questionnaire administered in interview or self-report format (CTQ, TAQ). All studies rely on retrospective recall and as such are subject to questions of reporting bias and validity. This is a common area of debate in the field and one that suffers from a paucity of empirical research (Widom, 2014). Further factors affecting the synthesis and integrity of the current review include partial or missing assessment of maltreatment factors, the use of measurement tools with poor or unknown

psychometric properties, and the capacity of samples to address issues of dose-response.

Firstly, with the exception of Ensink *et al.*, (2014) and Berthelot *et al.*, (2015) who report on severity and Pajulo *et al.*, (2012) reporting on type, the majority of the included studies consider global assessments of childhood trauma. Most do not address variables associated with the potential psychological impact of CM such as frequency, type of maltreatment (in particular whether there was physical or sexual abuse), perpetrator identity, revictimisation and co-occurrence, or timing. Differing definitions of abuse and different measurement tools with varying levels of psychometric integrity are also apparent across reviewed studies. It seems unlikely, therefore, that any of the identified studies have been able to offer a full analysis of factors relevant to CM.

Considering the psychometric properties of CM measures used in identified datasets, the measure of ‘deprived childhood’ described by Fonagy *et al.*, (1994), while evidencing acceptable inter-rater reliability, lacks further psychometric evaluation and the ability to discriminate and assess maltreatment factors. In their related studies, Ensink *et al.*, (2014) and Berthelot *et al.*, (2015) utilise the CECA, a relatively rigorous assessment tool and its psychometric properties including validity and inter-rater reliability are described as good. The measure is delivered as a semi structured interview assessing parental antipathy, neglect, physical abuse and sexual abuse scored by the investigator by reference to examples illustrating severity. The tool has the capacity to identify perpetrator identity and both type and severity of trauma experiences. Ensink *et al.*, (2016) rely on AAI responses to demand questions regarding past traumatic experiences to assess CM stating that this method has demonstrated reliability in previous studies. The authors cite Ensink *et al.*, (2014) in this respect although this is not explicitly discussed in that paper. Further, as a measure of trauma, the AAI is unvalidated and lacks the capacity to examine severity or type of maltreatment. Indeed, Ensink *et al.*, (2014) utilise the CECA and AAI to identify CM and conclude that the CECA offers a more comprehensive assessment.

The remaining five studies utilise questionnaire measures to examine CM. Pajulo *et al.*, (2012) stand alone using the TAQ, a 48-item questionnaire assessing positive and negative experiences by age and type of exposure. The measure, it is suggested, is widely used clinically. Published data reporting its psychometric properties is very limited, however. The CTQ was administered as a face-to-face interview by Stover & Kiselica (2014) and by telephone in the studies of Huth-Bocks *et al.*, (2014) and Stacks *et al.*, (2014) while Perry *et al.*, (2015) utilised it as a self-report measure. The CTQ utilises 28 items to assess experiences across domains of abuse and neglect. All papers combine scores for analyses to describe overall exposure. In an examination of the psychometric properties of the CTQ with a community sample of $n = 1007$ 18 to 35 year olds, Scher, Stein, Asmundson, McCreary, & Forde (2001) evidence that the tool can be applied by domain and as a higher-order ‘general childhood trauma’ construct, and report the measure’s good internal consistency. The CTQ appears to be an acceptable measure in this respect, therefore, and appropriately applied in these studies. However, it may be relevant to consider the potential for response bias introduced through inconsistencies in its delivery.

An additional area of concern regarding the current synthesis involves the relatively restricted ranges of CM experiences reported within some studies. For observational ‘exposure-outcome’ studies, assessment of dose-response relationships is thought to lend credibility to hypotheses concerning causality (NIH, 2004). Pajulo *et al.*, (2012) with their sample of mothers in a substance misuse treatment programme report a mean of 2.9 ($sd = 2.7$; range = 0-13) for TAQ responses from a possible range of 0-27 for assessment of abuse in early childhood. Given the population studied, this is perhaps a surprising descriptive. Further, Stover and Kiselica (2014) also suggest that their findings may be limited by a restricted range of CM CTQ scores (mean = 59.14, $sd = 9.94$, range 44-92; males). Analysis in relation to the community norms reported by Scher *et al.*, (2001) indicate scores are significantly raised for the population participating in Stover and Kiselica (2014; $t(101.4) = -22.89$, $p \leq 0.005$), however, it may be that without participants scoring in the upper ranges, the lack of association between CM and RF may be questionable. Similarly, Huth-Bocks *et al.*, (2014) state that although participants were oversampled for CM, demographic

characteristics suggested a relatively normative, well functioning group for whom severity of maltreatment experiences was relatively low. At the same time, Stacks *et al.*, (2014) using the CTQ, and Ensink *et al.*, (2014) and Berthelot *et al.*, (2015) with the CECA tool do report a range of maltreatment experiences which include the upper ranges. With these diverse samples, the authors appear to corroborate a lack of association. However, overall critical analysis indicated that measurement of CM significantly impaired the validity of the review's findings.

7.3.2 Measurement of reflective function

As discussed previously, identified studies examined the construct of RF either proximally to the infant as Parental RF, or distally by measuring Adult RF and this variability requires thought regarding conceptual differences of RF across groupings. Further, regarding mentalization and RF, Choi-Kain & Gunderson (2008) write that the “the broad territory of the concept paradoxically contributes to its familiarity as well as to its ambiguity” (p1128). The authors note that “adjacent” concepts of ‘theory of mind, ‘emotional intelligence’ and ‘mindfulness’ have developed measurement tools that are “less cumbersome” than RF scored from interview transcripts. On the other hand, RF measured from interview transcripts as in the current reviewed studies do not rely on self-report and as such may benefit from a degree of objectivity in this sense. The current paper presents critical evaluation of measurement of RF in relation to the psychometric properties of the tools used and the range of RF scores reported.

Firstly, adult RF was assessed by applying the Reflective Functioning Manual (Fonagy *et al.*, 1991b and 1998) to AAI transcripts. The RF scale is well used in the research literature (Katznelson, 2014) and its psychometric properties are considered to be good (Taubner *et al.*, 2013). RF-T (Adult RF regarding CM experiences specifically) was also assessed via verbatim responses to demand questions in the AAI (Ensink *et al.*, 2014; Berthelot *et al.*, 2015). This scale was developed by the study authors and information regarding reliability of the tool are limited to the source papers which report excellent inter-rater agreement. However, the validity of the tool has yet to be demonstrated and requires further examination. Parental RF

was assessed antenatally using the PI (Pajulo *et al.*, 2012) or its revised form PI-R (Perry *et al.*, 2015), and postnatally with the PDI (Perry *et al.*, 2015) and its revised formats: PDI-R2-S (Huth-Bocks *et al.*, 2014; Stacks *et al.*, 2014) and PDI-R (Stover & Kiselica, 2014). Both the PI and the PDI are reported to show good inter-rater reliability and validity.

While both constructs appear robust psychometrically speaking, it is again necessary to consider whether amalgamation of findings across these measures is appropriate. Both tools originate from the work of Fonagy *et al.*, (1991b) who developed the RF manual to assess RF from AAI transcripts. Slade (2005) describes adapting AAI RF codes for use with the PDI (Aber, Slade, Berger, Bresgi, & Kaplan, 1985), a 45-item semi-structured clinical interview around parents' representations of their children, parenting, and relationships with their children. Similarly, the PI (a 24-item semi-structured interview regarding the emotional experience of pregnancy, relationship with baby, own mother and partner; Slade *et al.*, 2004) was developed from the RF scale developed by Fonagy *et al.*, (1994) to assess RF during pregnancy.

Ensink *et al.*, (2016) conclude that RF regarding past attachment relationships appears to be of similar import as more proximal parental measures in relation to infant disorganisation. However, although grounded in the same system these measures derive from different interviews and consider different representational systems. Using the AAI interviewees reflect on relationships, incidents and memories from the past ("solidified" representations from stored memory), while the PI/PDI accesses current parent-child relationships with present-day examples (dynamic ongoing construction of representations; Slade, 2005). Conceptually, the tools may measure different qualities of mentalization. AAI derived RF appears to measure "solidified" trait-like aspects of mentalization while the PI and PDI may relate more to variations in mentalization dependent on the dynamic interpersonal context between parent and infant.

A number of the included studies discuss the range of identified RF scores as they interpret findings. This may be important to consider in relation to the current

review's confidence in reporting a non-significant association between CM and Adult/Parental RF. For example, Stover *et al.*, (2014) note a restricted range of PDI scores (mean = 3.14, sd = 0.86, possible range = -1 to 9). Pajulo *et al.*, (2014) too describe restricted PI scores (mean = 2.4, sd = 1.3, range = 0-4.5; n = 19) and PDI scores (mean = 3.0, sd = 3.0, range = 1-5; n = 29) for their sample of mothers engaging in treatment for substance misuse. Reference to clinical cut offs for the measure (-1 = rejection of RF, 0-2 = very weak, 3 = weak, 4-5 = normal, 6-9 = higher or exceptionally high) indicates 'very weak' to 'weak' RF capacity overall. It is possible that confounds associated with impairments in RF attributable to substance use can explain these low scores and that they may also affect the CM-RF finding. On the other hand, Stacks *et al.*, (2014), with a more representative, community-based population replicate the lack of association in analyses that include a wide range of RF scores (1-8, mean = 4.57, sd = 1.47). A tentative conclusion may be, therefore, that the lack of association between CM and Parental RF may not be attributable lack of variation in RF scores.

7.4 Population

The identified papers report variously on mothers from: community samples with very low levels of deprivation (Fonagy *et al.*, 1994); community samples of mothers oversampled (Stacks *et al.*, 2014; Huth-Bocks *et al.*, 2015) or sampled exclusively (Ensink *et al.*, 2014; Berthelot *et al.*, 2015; Ensink *et al.*, 2016) for experiences of CM; mothers in a drug misuse treatment programme (Pajulo *et al.*, 2012); substance misusing mothers involved in child protection proceedings vs. a community control sample (Perry *et al.*, 2015); and fathers with IPV and/or substance misuse relative to a community comparison group (Stover *et al.*, 2014).

The apparent consistency across studies regarding the lack of association between CM and caregiver RF must be considered in relation to these population differences. The inclusion of Stover & Kiselica (2014) who investigated CM and RF with a sample of fathers raises a question of the benefits of a 'broad church' approach regarding the inclusion criteria applied to select studies against the difficulties of

interpretation when comparing ‘apples with oranges’ (Boland, Cherry & Dickson, 2013).

Synthesis of the findings is also difficult when considering populations affected by substance misuse where sample sizes tend to be smaller and confounds are difficult to separate in analyses. Lower levels of RF within these samples may be attributable to weakened brain function regarding emotional regulation (Suchman, DeCoste, Leigh, & Borelli, 2010) and interference with reward systems supporting maternal preoccupation (Pajulo *et al.*, 2012). It is also possible that the impact of drug use on the infant’s temperament may be a complicating factor. Parenting an infant whose behaviour is more dysregulated with extremes of distress (and potentially more triggering, therefore, of emotion-based trauma responses), and harder to read likely requires greater RF. Mentalizing and RF in these circumstances may be impaired not only by the effects of substances, therefore, but also the greater stress aroused when interacting with a substance exposed infant.

Finally, it is also important to note the western cultural bias maintained across the identified studies which were limited to English language publications, and the implications of this when considering non-western populations.

8. Discussion

An immediately apparent observation of the current review is the interval between the original discussion of Fonagy *et al.*, in 1994 and the more recent emergence of further studies exploring this relationship. While Fonagy *et al.*, (1994), do not report tests of association, and notwithstanding the methodological issues noted, there appeared to be consistency in the reporting of subsequent datasets. None noted a statistically significant association between CM and RF in relation to parenting and it is tempting to conclude that this suggests a negative finding. A tentative implication, based on this limited pool, might state that the experience of trauma in childhood *per se* may not impact on RF related to parenting thus echoing the statement of Fraiberg *et al.*, (1975) that “history is not destiny” (p389). Considered against the strength of

opinion in the literature that “the capacity for mentalizing is undermined in most people who have experienced trauma” (p429, Allen, Lemma, & Fonagy, 2012) such an interpretation would warrant further investigation.

However, affording weighting based on quality ratings of the datasets, and excluding those rated as poor (Perry et al., 2015), this finding is derived from only 5 datasets. Further dividing the datasets across conceptual delineations reduces the pool to include non-significant correlations described separately by two datasets reporting analyses of CM and adult RF, and three reporting analyses of CM and parenting RF. Interpretation based on such small numbers is extremely limited, and may be further undermined by the review’s broad inclusion criteria regarding population. Realistically, therefore, no firm conclusions can be drawn regarding the original study question.

Considering the reviewed papers more broadly within conceptually comparable subsets, the current study has noted the crossover of findings within in the literature which may be useful to consider. The original findings of Fonagy *et al.*, (1994) regarding CM and RF are described within a protective model of resilience. In their low-risk, community sample, mothers who had experienced maltreatment who scored high in RF were more likely to have infants who were securely attached at 12-months relative to infants of maltreated mothers with low RF. Notwithstanding the low study quality rating of the original study, the more recent dataset examined by Ensink *et al.*, (2014) and Berthelot *et al.*, (2015), quality rated good and fair respectively, further refine this finding in relation to disorganized attachment. The studies suggest that, for mothers with maltreatment histories, the capacity to specifically reflect on or mentalize past traumatic experiences may be important to recognise alongside assessment of context dependent, state-like mentalization in the development of disorganized attachment relationships in infants. Further exploration of how RF-T is facilitated in the context of CM and how this impacts on parenting RF, therefore, may represent an important area for further research.

In addition to investigation of RF-T resilience, the impact of RF-T on observed parenting behaviours is a further area of interest. Katznelson (2014) notes that interventions designed to promote ‘at risk’ parents’ mentalization of their infants are equivocal as to whether this leads to behavioural change. Pending replication, the studies of RF-T reviewed indicate that specific assessment of RF-T (as a trait-like expression of mentalization) alongside therapeutic intervention may facilitate a parent’s capacity for state-like mentalization within triggering moments of parenting.

9. Conclusion

The current paper presents a review of the literature reporting on the relationship between experience of childhood maltreatment and reflective function in later parenting. After a systematic search of relevant literature search databases, the quality and content of seven datasets, of which nine papers, were considered. Interpretation of findings regarding an apparent lack of statistically significant association between the CM and RF was limited however due to reduction of the data pool after study quality and conceptual delineations were considered. In addition to the small number of studies identified, variability in assessment of CM and lack of information regarding factors interacting with this variable limits the review’s capacity to draw firm conclusions. A more comprehensive exploration of the factors associated with CM and attention to conceptual clarity regarding mentalization is required if the impact of CM on later RF in the context of parenting is to be more meaningfully understood.

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Immediately after the abstract, provide a maximum of 6 keywords, using American spelling and avoiding general and plural terms and multiple concepts (avoid, for example, 'and', 'of'). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.

Formatting of funding sources

List funding sources in this standard way to facilitate compliance to funder's requirements:

Funding: This work was supported by the National Institutes of Health [grant numbers xxxx, yyyy]; the Bill & Melinda Gates Foundation, Seattle, WA [grant number zzzz]; and the United States Institutes of Peace [grant number aaaa].

It is not necessary to include detailed descriptions on the program or type of grants and awards. When funding is from a block grant or other resources available to a university, college, or other research institution, submit the name of the institute or organization that provided the funding.

If no funding has been provided for the research, please include the following sentence:

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Footnotes

The use of footnotes in the text is not permitted. Footnoted material must be incorporated into the text.

Table footnotes Indicate each footnote in a table with a superscript lowercase letter.

Appendix 2: University of Edinburgh research ethics approval documentation



SCHOOL OF HEALTH IN SOCIAL SCIENCE
CLINICAL PSYCHOLOGY

The University of Edinburgh
Medical School
Doorway 6, Teviot Place
Edinburgh EH8 9AG

Telephone 0131 651 3969
Fax 0131 650 3891
Email submitting.ethics@ed.ac.uk

Melanie Gunning
Trainee Clinical Psychologist
University of Edinburgh

09 December 2014

Dear Melanie,

Application for Level 1 Approval

Re: A grounded theory exploration of Social Workers' experiences of balancing conflicting frameworks and agendas within child protection and permanence planning

Thank you for submitting the above research project for review by the Section of Clinical Psychology Ethics Research Panel. I can confirm that the submission has been independently reviewed and was approved on the 24th November 2014.

Should there be any change to the research protocol it is important that you alert us to this as this may necessitate further review.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'K. Gardner'.

Kirsty Gardner
Administrator
Clinical Psychology

Appendix 3: Participant information sheet

Participant Information Sheet

Study title: A grounded theory exploration of social workers' experiences of working within agendas and frameworks within permanence planning

Introduction

My name is Melanie Gunning and I am a clinical psychology trainee employed by NHS Lothian and studying at the University of Edinburgh. As part of my training I am conducting a research study that explores social workers' experiences of working within child protection. My work on this study is supervised by Dr. Tara Pennington-Twist (Clinical Psychologist, NHS Lothian & East Lothian Council's Children's Services) and Dr. Jill Cossar (Lecturer, The University of Edinburgh).

What is the purpose of this research study?

The aim of this study is to increase understanding in this area to inform the development of supportive practices that facilitate best outcomes for children and families.

Do you have to take part?

Participation in this study is entirely voluntary and your decision to not take part or to withdraw your participation will not have any negative consequences for you.

What will you do in the project?

The study will use a qualitative methodology (grounded theory) which means that participants will be asked to take part in an in-depth interview which will last for up to an hour, exploring their real experiences of working in this area. Interviews will be conducted at a venue arranged by agreement between the researcher and participant. The information will be analysed and common categories will be used to develop a way to describe how social workers experience working in this complex area.

Why have you been invited to take part?

You have been approached to take part in this study as you are a qualified social worker with more than one year of experience, currently working actively in child protection and planning for permanence.

What are the potential risks to you in taking part?

There are no identified risks to taking part in this research study.

What happens to the information in the project?

Participant information will be entirely confidential and participants will be prompted to speak about their experiences without identifying individual children or families. The interviews will be audio recorded and audio files will be stored securely for the duration of the study only. The recordings will be transcribed for data analysis and any identifiable information will be anonymised and all personal data on participants will be processed in accordance with the provisions of the Data Protection Act 1998.

Once the study is complete the findings will be written up as a research document which will be summarised for academic and/or professional publications and presented at talks and meetings for relevant professionals. No identifying information will be used in any written or presented work. It is hoped that this study will develop our understanding of the complexities of working in this area and will therefore inform working practice and service development.

Thank you for reading this information – please email me on s9251687@sms.ed.ac.uk to ask any questions if you are unsure about what is written here.

What happens next?

If you are interested in taking part in the study, please discuss this with your line manager and contact me by phone or email.

Once participation has been discussed and any questions you might have have been answered you will be asked to sign a consent form to confirm this.

It is expected that the study will be completed by May 2016. After this point, the study the findings will be available from the researcher by email.

If you are not interested in taking part, no further action is required. Thank you for reading this information sheet.

Researcher contact details:

Melanie Gunning

*c/o: University of Edinburgh/NHS
Scotland Clinical Psychology Training
Programme
School of Health in Social Science
The University of Edinburgh
Medical School (Doorway 6),
Teviot Place,
Edinburgh, EH8 9AG
Email: S9251687@sms.ed.ac.uk*

If you have any questions/concerns, during or after the investigation, or wish to contact an independent person to whom any questions may be directed or from whom further information may be sought from, please contact:

*Clinical Psychology Research Ethics
School of Health in Social Science
The University of Edinburgh
Medical School (Doorway 6),
Teviot Place,
Edinburgh, EH8 9AG
Email: resethic@ed.ac.uk*

Ethical Review

This investigation was granted ethical approval by East Lothian Council and The University of Edinburgh Ethics Committee.

Appendix 4: Informed consent form

INFORMED CONSENT FORM

PROJECT TITLE

A grounded theory exploration of social workers' experiences of working within agendas and frameworks within permanence planning

PROJECT SUMMARY

This project aims to explore social worker's experiences of their work within child protection and permanence planning. The researcher, Melanie Gunning, is a Clinical Psychology Trainee at the University of Edinburgh supervised by Dr. Tara Pennington-Twist (Clinical Psychologist, NHS Lothian) and Dr. Jill Cossar (Lecturer, The University of Edinburgh). The project has been granted ethical approval by East Lothian Council and The University of Edinburgh.

By signing below, you are agreeing that: (1) you have read and understood the Participant Information Sheet, (2) questions about your participation in this study have been answered satisfactorily, (3) you are aware of the potential risks (if any), and (4) you are taking part in this research study voluntarily.

Participant's Name (Printed)

Participant's signature

Date: _____

Name of person obtaining consent (Printed)
consent

Signature of person obtaining

Date: _____

Appendix 5: Text extracts of preliminary open questions (following brief discussion regarding professional history in permanency role)

Interview 1

“OK. And I...it’s that area of your experience as well as your current area that we will think about today. I’m interested in hearing about what it’s like for you as Social Workers working in your role in planning for permanence. What can you tell me about that?”

Interview 2

“So I’m interested to find out what it’s like for you as Social Workers working in your role in planning for permanence {mhmm}. It’s really just a very free-flowing, informal chat to find out what your experiences are {yes, yes} in terms of what it can be like for you. So, what can you tell me about that- about working as a social worker in permanency to get us started off and then we’ll see how it unfolds? {yes, yes}. There’s no right or wrong to it, we’ll just see how we go”

Interview 3

“OK, so that’s helpful regarding your role in permanence work at the moment. Can you tell me more about that now...about what it is actually like to be a social worker working in permanency?”

Interview 4

“Yeah. Ok. And I think you’ve started talking about what is the aim of the study now: to find out about what it’s like for you as Social Workers working in your role in planning for permanence”

Interview 5

“Yes, that’s what I was thinking. You’ve got all these fingers in different areas then. I’m really interested to hear more about what it’s like for you as a social worker and for the social workers you work with to work in this specific area of planning for permanence”

Interview 6

“Okay. Well the broad question is, so... What’s it like working in this area? Specifically thinking about permanence? Because I’m interested to hear what workers tell me about working in planning for permanency”

Interview 7

“That’s really interesting. And it’s all related to the main interest for this study. I want to find out more about what it’s like for you as a social worker having a role in permanence work. You were talking about your practice work there. Can you talk me through an example?”

Interview 8

“I’m interested to hear more about that part of your work, in permanency – what can you tell me about what it’s like for you as a social to work in this specific area of planning for permanence?”

Appendix 6: Coding extracts

Interview 1:

Emergence of 'child's mind in mind' category (red).

	Transcript	Coding
Interviewer	And what's that experience like...from your practice, kind of negotiating with children's hearing's panel or presenting your case?	
SW1	My experience is quite mixed I think. I think that a lot of social workers feel that panel members possibly tend to...feel too sympathetic towards {mhmm} birth family who are maybe presenting as upset or tearful {mhmm} and...you know...pulling at the heart strings {mmmm}. And it does, you know...it does I mean it is heart breaking to hear it {mhmmm}. But...I think if Social Workers present their reports well enough then generally {mhmmm} panel members will understand {okay} you know what the plan is and why it is in place {mhmmm}.	Childrens panel; Mixed experience; Collective sense; Children's panel too sympathetic; parents presenting as tearful; feeling sympathy; Feeling sympathy; Heart breaking to hear parent's story; presenting SW reports; Quality of SW reports; influencing children's panel; communicating permanency plan; providing rational
Interviewer	OK. What do you think does make a well presented report?	
SW1	I think...I think one where the panel can easily see the evidence is what has happened, the abuse and or the neglect...and...but what the negative impact of that has all been for the	SW reports; quality =accessibility; evidence of events;child's experiences; Negative effect on child;

Interviewer	<p>child...attachment and his development...and how we can make predictions on what might happen next for him, in the future, if nothing changes.</p> <p>Do you have any specific examples you can think of where that's kind of happened? Where...</p>	<p>attachment; child's development; predicting future; if nothing changes</p>
SW1	<p>Emmm....well I think...so thinking about contact maybe...I think sometimes we will present a case where we think that em it's disruptive to the child's placement to, for example, see their birth parent three times a week when we've already come to a conclusion that a {mhmmm} rehabilitation plan for that family {Mhmmm} isn't going to happen {mhmmm}. And we would actually think that the main task for that child would be to be at home with the foster parents particularly when they're very young rather than being carted to and from contacts...um...even if it's not...the child's not openly distressed by that contact {mmmm} then it could be still quite disruptive and...um...so we would say 'we think contact should be reduced' and the panel might see mum's presentation in the hearing, and say 'yeah but we're not seeing any signs that the</p>	<p>Contact decisions; Presenting case; decision making; foster placements; considering child's experience; frequency of contact; contact vs. SW conclusions; decision making; rehabilitation; Decision making; Finality; Considering child's needs; attachment; child's experiences; child's developmental stage; contact=child as object?; child's current distress; interpreting evidence of harm; impact on child; SW reports; recommending; children's panel-feeling sorry for parent; panel relying on overt behaviour;</p>

	<p>child's being distressed by...{mhmm} by this. You know they're not running away scared as soon as they see their birth parent'. But you know...what sometimes helps is trying to explain how you know...that....sort of the primary task of a really young child...forming attachments is likely to be disrupted {mmmm} if they're carted off to some contact three times a week and then spend time in company of someone {mmmm} they're probably not that sure about {yeah} and so if...if...you can't directly see that... obviously if the parent comes in and starts shouting and screaming at the child and the child's terrified then you could say well it's clearly detrimental to the child. But I think when it's more subtle and it's to do with...with interfering with their...their potential {mmmm} to form secure attachments it's less obvious to people...it's harder to explain. On the other hand it is easier to see the parent right in front of you.</p>	<p>child's overt distress; contact; trying; influencing panel; explaining to panel; Explaining child's needs; Attachment; effects on child; contact-child as object; contact; frequency; Child's experience of contact; Child not sure about parent; can't see child's thoughts; contact; Emotional abuse; Child's overt distress; Evidence of harm; clarity of interpretation; effects on child are subtle; Evidence of harm; Child's potential; future; attachment less obvious; can't see attachment vs. easy to see parent</p>
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Coding memo

Memo illustrating the researcher's reflections regarding the social worker's thinking around the child's psychological experience:

Coding memo after SW1 interview (exerpt): *Describes social workers reports as communicating an interpretation of the emotional/psychological impact on the child to*

panel who are perceived as relying on overt and current behaviours of child in contact or parent in room. Worker has to explain the things that can't be easily seen (emotional dimensions and their future emotional/psychological impacts) to panel. In contrast it is easy for the panel to see the parent.

Interview 2: Developing 'child's mind in mind' category and emergence of interaction with 'emotional demands' -> 'interpersonal' category (green)

	Transcript	Coding
Interviewer	So what em...what's the emotional picture for yourself, holding all that? {Em }What's that like?	
SW2	It's really hard. 'Cause you do...cause then...like...I always think, in that case...that when you read about this case...it's very, if there was ever a serious case review on this case I think they would say 'you had all the information'. But the problem is, that was...we had all the information from family but we didn't have the information that we needed when we went out on visits {mhmm}. But y' you do still worry. But anyway apart from...that, that's me thinking about myself in a serious case review but what it's like holding on to the worry about the children is, is you just think 'what...I wish I could have protected them more and gotten them out sooner' {mhmm}. So, so...em...I mean, he's 4 now this boy. He's going to be so damaged as	Emotionally hard. Reflecting Scrutiny Professional consequence Weight of evidence Problem for case Gathering evidence indirect vs. direct Home visits Worrying Mentalizing self Self protection Holding worry for child Protecting child Failing child Age of child Anticipating the future

Interviewer	it is {mmm} you know, and it's...it's em...yeah. So emotionally that's not good. Ummm	Damage to child Emotionally not good
SW2	I suppose it's both really isn't it? Sounds like you're worrying professionally and then - what are the ramifications and consequences for the children... Yes, yes, that's it exactly. And em...I've got another one that I'm doing at the moment and...[sigh]...that's a really tough one. 'Cause mum, I really like and I feel so sorry for this poor mother. And em, but I know it's the right thing for the children. But emotionally...and there's a lot of delay in this case {okay}. And I just think that the more delay there is, the more that we're damaging children. {mmm}. And that's awful	Sources of worry Doing permanency Emotionally tough Liking parent Feeling for parent Maintaining focus ↓mentalizing self?; Delays Accumulating delays Responsibility Damage to child Emotionally awful
Interviewer	Tell me more about that – where you feel sorry for the mum but you are seeking permanence for the child- what's that like?	
SW2	Well it's hard. Really hard.	Emotional weight
Interviewer	So what do you think about...what did you notice about what happened with that case?	
SW2	[Sigh] I think that mum...I think that we were	Emotional weight (sigh);

	<p>really hopeful when she was well but there was this pattern...and mum has been really risky and harmful for the kids...but then well again when she was pregnant but it wouldn't be lasting. And the kids were there and out, and there and out because of that...but really the overall pattern wasn't changing for mum and the kids were going through it all...but we were so wanting it to work that what was actually happening for them... emotionally while all that was going on ... well... we were focussed on giving mum another chance...and that meant that it took longer to get to this point.</p>	<p>Hoping for parent change; Seeing pattern in parent's history; maltreatment; harm to child; pregnancy; change doesn't last; child's experience; Effect on child-inconsistency; No parental change; Effects on child; Hoping for parent change; vs. child's emotional experience; time passing focus on parent vs. child's experience; supporting parent; delay for child.</p>
Interviewer SW2	<p>Ok- maybe talk me through it if that's ok? [....description of case work and parental breakdown....]</p> <p>So anyway, we did that and it all fell flat on its face. And mum became unwell again. And the children were accommodated. And at that point we said 'Enough'. {okay} Right this is...by that point, this wee girl was 5. And she'd been in foster care 3 times. So this was enough and we're not, we're not doing this anymore. Because it wasn't fair on them...they were having to make and break</p>	<p>Intervention and breakdown; parenting patterns; removing child; reaching threshold; Time passing; Child in repeat placements; reaching threshold; decision making; not fair on child; focus- shift to child; child's relationship</p>

	<p>with fosterers, they were only wee but you'd guess that they'd learnt not to believe that mum or anyone would stay around and they...emotionally...the stress of all that for them. So many people coming and going and disappearing. And we could see was happening. So that was last, that was June 2014 that we made that decision. And em...but...we, everything was working on a voluntary basis at this point so it's like, em, a section 25? Do you know what I mean by that?</p>	<p>disruptions; child's age; guessing child's mind; child's thinking; parental inconsistency; child's emotions; child's stress; child's relationship disruptions; witnessing effects on child; time passing; decision making; working with parent's agreement; types of order; section 25</p>
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Coding memos

> Illustrating the development of coding the participant's comments about the child's experiences across different domains and emergence of 'child's mind in mind' category:

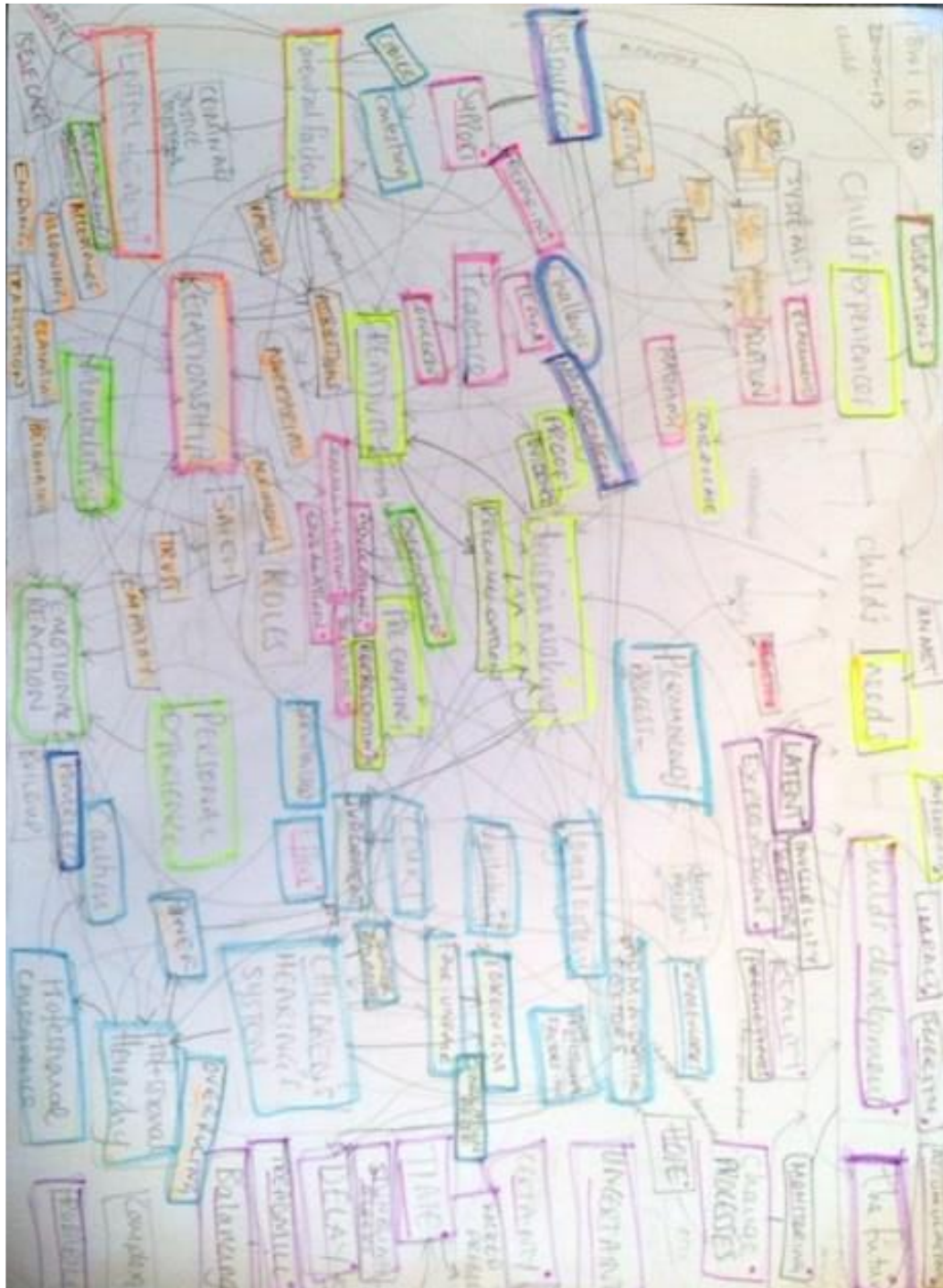
Coding memo after SW2 interview: *SW2 talks about the child's experience in different ways- emotional, psychological- in addition to description of the parent's parenting or neglect/abuse -> what has happened to the child as well as what it means for the child.*

> Illustrating the emergence of conceptual links between codes describing the experience of 'liking the parent', focus on the parent, and delays for permanency.

Coding memo after SW2 interview: *Feeling sorry for the parent seems to be linked to the length of time for this child to reach permanency as the worker / the system gave her so many 'chances' but the pattern repeated for the child.*

Appendix 7: Example of diagramming after initial coding of SW1

Codes were handwritten onto A3 sized paper and colour coded into related categories. With further interviews, new sheets were devised and existing codes incorporated and grouped to form focussed codes and related focussed codes to form theoretical codes.



Appendix 8: Author guidelines for submission to the *Infant Mental Health Journal*

From: <http://onlinelibrary.wiley.com/journal/10.1002/%28ISSN%291097-0355/homepage/ForAuthors.html>

Author Guidelines

NIH Public Access Mandate

For those interested in the Wiley-Blackwell policy on the NIH Public Access Mandate, [please visit our policy statement](#)

Author Guidelines

The *Infant Mental Health Journal* (IMHJ) is the official publication of the World Association for Infant Mental Health (WAIMH) and is copyrighted by the Michigan Association for Infant Mental Health.

Information for Contributors

Reflecting the interdisciplinary nature of the field, its international focus, and its commitment to clinical science, the IMHJ publishes research articles, literature reviews, program descriptions/evaluations, clinical studies, and book reviews on infant social–emotional development, caregiver–infant interactions, and contextual and cultural influences on infant and family development. The Journal is organized into three sections: Research, Clinical Perspectives, and Book Reviews. Research focuses on empirical research. Clinical Perspectives allows for more diversity in types of submissions and is designed to advance infant mental health practice and scholarship. Requests for book reviews should be sent by the author or publisher to the Editor In Chief. Please do not send a copy of the book until the request is approved.

The Journal welcomes a broad perspective and scope of inquiry in infant mental health and has an interdisciplinary and international group of associate editors, consulting editors, and reviewers who participate in the peer review process. In addition to regular submissions to the Journal, proposals for special issues or sections are also welcome. These should be discussed with the Editor In Chief prior to submission.

MANUSCRIPTS for submission to the *Infant Mental Health Journal* should be forwarded to the Editor as follows:

1. Go to your Internet browser (e.g., Netscape, Internet Explorer).
2. Go to the URL <http://mc.manuscriptcentral.com/imhj>
3. [Register](#) (if you have not done so already).
4. Go to the Author Center and follow the instructions to submit your paper.
5. Please upload the following as separate documents: the title page (with identifying information) and all remaining files without any identifying information, including the

body of your manuscript, and each table and figure. Please note that the cover letter is uploaded directly into a field in the on-line submission platform.

6. The Title Page should include a discussion of any conflicts of interest, human subjects approvals, and funding. Acknowledgements may also appear here. The *Infant Mental Health Journal* complies with all relevant recommendations from the International Committee of Medical Journal Editors in these areas.
7. Your abstract should be uploaded into the appropriate field at the submission website and should also be included in the main text of the manuscript. The abstract in the manuscript must include 3-5 key words listed at the end of the text.
8. Please note that this journal's workflow is double-blinded. Authors must prepare and submit files for the body of the manuscript and any accompanying files that are anonymous for review (containing no name or institutional information that may reveal author identity).
9. All related files will be concatenated automatically into a single .PDF file by the system during upload. This is the file that will be used for review. Please scan your files for viruses before you send them, and keep a copy of what you send in a safe place in case any of the files need to be replaced.
10. Style must conform to that described by the American Psychological Association *Publication Manual*, Sixth Edition, 2009 (American Psychological Association, 750 First Street, N.E., Washington, D.C. 20002-4242). Authors are responsible for final preparation of manuscripts to conform to the APA style.

Manuscripts generally do not exceed 10,000 words and will be assigned for peer review by the Editor or Associate Editor(s) and reviewed by members of the Editorial Board and invited reviewers with special knowledge of the topic addressed in the manuscript. The Editor retains the right to reject articles that do not meet conventional clinical or scientific ethical standards. Normally, the review process is completed in 3 months. Nearly all manuscripts accepted for publication require some degree of revision. There is no charge for publication of papers in the *Infant Mental Health Journal*. The publisher may levy additional charges for changes in proofs other than correction of printer's errors. Authors have the option to participate in Wiley's OnlineOpen program which allows authors of primary research articles to make their article available to non-subscribers on publication and archive the final version of their article. With OnlineOpen, the author, the author's funding agency, or the author's institution pays a fee to ensure that the article is made available to non-subscribers upon publication via Wiley Online Library, as well as deposited in the funding agency's preferred archive. For more information, please visit the [OnlineOpen page](#).

Proofs will be sent to the corresponding author and must be read carefully because final responsibility for accuracy rests with the author(s). Author(s) must return corrected proofs to the publisher in a timely manner. If the publisher does not receive corrected proofs from the author(s), publication will still proceed as scheduled.

Additional questions with regard to style and submission of manuscripts should be directed to the Editor: Paul Spicer, PhD, at paul.spicer@ou.edu

Appendix 9: Systematic review protocol

Adapted from CRD (2009) guidance

Review question

To synthesise the empirical literature regarding the association between parental experiences of CM and later reflective function in relation to parenting.

Inclusion criteria

Participants: Adult primary caregivers who report experiencing CM up to the age of 18 years.

Exposure: CM defined as the parent's experience of emotional, physical abuse and/ or neglect and/or sexual abuse which occurred before 18 years of age. Studies investigating Type 1 (single event) trauma or where the measurement of trauma not restricted to childhood will be excluded.

Outcome: Parenting reflective function defined as a measure of mentalizing processes in relation to parenting including own experiences of being parented or of parenting their child.

Study design: Empirical research will be considered including randomised controlled trials (RCTs), controlled trials, cohort studies with and without comparison groups and cross-sectional studies. Case series, case reports and qualitative findings will be excluded from the review.

Language: English language.

Publication type/status: Published, peer reviewed papers.

Research evidence

Evidence will be assessed using searching of electronic databases, visual scanning of reference lists from relevant studies, handsearching key journals, searching relevant Internet resources, and citation searching. Search results will be documented in Word format.

Managing references

Refworks, Copyright 2016, ProQuest LLC.

Study selection

Stage 1: Titles/abstracts will be assessed against the inclusion criteria for inclusion, erring on the side of over-inclusion. Rejected studies will be recorded simply as

‘excluded’ should they be clearly irrelevant. Reasons for the exclusions of citations that meet topic criteria but do not adhere to one or more inclusion criteria will be recorded. Stage 2: When assessment of inclusion criteria is unclear the full paper will be obtained for detailed review. Any further uncertainty will be resolved via consensus review with a second reviewer.

Study selection will be documented in Word format and presented utilising Moher, Liberati, Tetzlaff, Altman, & The PRISMA Group (2009) guidance.

Data extraction

The following standardised data extraction will be utilised.

Study number	Authors, date, title, type of publication
Aim	Including country of origin
Sample	
Study design	
Methods	
Trauma/RF measures	
Analysis and results	Statistical analyses:
	Results:
Trauma/RF analysis	
Limitations	
Generalisability	
Include	YES / NO

Quality assessment

The review will pilot and utilise a tool developed to assess the quality of included studies which draws on the Scottish Intercollegiate Guidelines Network Methodology Checklist 3: Cohort Studies (SIGN, 2004) and the National Institutes of Health Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies (NIH, 2014). Inter-rater agreement between the author and an independent reviewer will be analysed and the use of consensus agreement will be recorded as appropriate.

Data synthesis

Synthesis of the data will be conducted initially by tabulating included studies and presenting an overview of study quality. Further a narrative synthesis will consider the relationships within and between studies alongside an overall assessment of the robustness of the evidence.

Appendix 10: References for excluded studies organised by exclusion criterion

No childhood trauma measure / adult and child combined

Ammaniti, M., Tambelli, R., and Odorisio, F. (2013). Exploring maternal representations during pregnancy in normal and at-risk samples: the use of the interview of maternal representations during pregnancy. *Infant Ment. Health J.* 34, 1–10. doi: 10.1002/imhj.21357

Bailey, H. N., Moran, G., Pederson, D. R., & Bento, S. (2007). Understanding the transmission of attachment using variable- and relationship-centered approaches. *Development and Psychopathology*, 19, 313–343.

Borelli, J. L., West, J. L., Decoste, C., & Suchman, N. E. (2012). Emotionally avoidant language in the parenting interviews of substance-dependent mothers: Associations with reflective functioning, recent substance use, and parenting behavior. *Infant mental health journal*, 33(5), 506–519

Capstick, C., Slade, Arietta, Hien, Denise, Jurist, Elliot, Gomes, Hilary, & Tuber, Steven. (2008). *The Role of Higher-order Cognition in Parental Reflective Functioning: A Correlational Study of Executive and Reflective Capacities and the Related Contributions of Substance Abuse and Depression*, ProQuest Dissertations and Theses.

Daley, A., Slade, Arietta, Anglin, Deidre, Diamond, Diana, Punales, Diana, & Tuber, Steven. (2013). *Reflective Functioning and Differentiation-Relatedness During Pregnancy and Infant Attachment Outcomes at One Year*, ProQuest Dissertations and Theses.

Demers, I., Bernier, A., Tarabulsky, G.M., Provost, M.A. (2010). Maternal and child characteristics as antecedents of maternal mind-mindedness. *Infant Ment. Health J.* 31 (1) 94–112.

Ensink, K., Bégin, M., Normandin, L., & Fonagy, P. (2016). Maternal and child reflective functioning in the context of child sexual abuse: Pathways to depression and externalising difficulties. *European Journal of Psychotraumatology*, 7, 30611.

Fitzpatrick-Behnke, E., Hans, Sydney, Taub, Richard, Woodward, Amanda, & Suth, Andrew. (2014). *Exploring Reflective Function, Attachment, Risk, and Substance Abuse*, ProQuest Dissertations and Theses.

Grienberger, J. F., Kelly, K., & Slade, A. (2005). Maternal reflective functioning, mother-infant affective communication, and infant attachment: Exploring the link between mental states and observed caregiving behavior in the intergenerational

transmission of attachment. *Attachment & Human Development*, 7, 299–311.
<http://dx.doi.org/10.1080/14616730500245963>

Herwitz, J., & Eagle, Morris. (2003). *Parenting against the Odds: Psychological Mindedness among Resilient Adolescent Mothers*, 187 p.

Kearney, J., & Cushing, E. (2012). A Multi-Modal Pilot Intervention with Violence-Exposed Mothers in a Child Psychiatric Trauma-Focused Treatment Program. *Issues in Mental Health Nursing*, 2012, Vol.33(8), P.544-552, 33(8), 544-552.

Madigan, S., Moran, G., Pederson, D., & García Coll, Cynthia. (2006). Unresolved States of Mind, Disorganized Attachment Relationships, and Disrupted Interactions of Adolescent Mothers and Their Infants. *Developmental Psychology*, 42(2), 293-304.

Pajulo, M., Suchman, N., Kalland, M., Sinkkonen, J., Helenius, H., & Mayes, L. (2009). Role of the maternal reflective ability for substance abusing mothers. *Journal of Prenatal and Perinatal Psychology and Health*, 23(1), 13–31.

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Appendix 11: Quality criteria for systematic review

Adapted from: Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies. National Institutes of Health, and SIGN Methodology Checklist 3: Cohort Studies.

Version 04/03/16

	Quality Criteria*	Rating
1	Research question is clearly defined (SIGN 1.1 and NIH 1)	
2	Study populations are clearly defined and comparable (SIGN 1.2 and NIH 2)	
3	Sampling procedure and participation rates (SIGN 1.3 and NIH 3)	
4	Attrition rates reported (SIGN 1.5/1.6 and NIH 13)	
5	Sample size (NIH 5)	
6	Exposure measures and assessment (SIGN 1.10 and NIH 9)	
7	Different levels of the exposure of interest are defined and assessed (NIH 8)	
8	Outcome measures are valid and reliable (SIGN 1.11 and NIH 11)	
9	Main potential confounders identified and accounted for (SIGN 1.13 and NIH 14)	
10	Blinding (SIGN 1.8/1.9 and NIH 12)	

* Consult relevant source papers where relevant to establish criteria

Overall assessment of study quality	
Good	Majority of criteria (6/10) are 'good'. The results reported in the study can be attributed to the exposure being evaluated and not to flaws in the design or conduct of the study. The risk of potential for selection bias, information bias, measurement bias, or confounding is low. The study is able to draw associative conclusions about the effects of the exposures being studied and the relevant outcomes as exposures are measured prior to outcomes, dose-response gradient is detailed, measurement of exposure and outcome are likely accurate, and confounding is addressed.
Fair	Majority criteria good or adequate (6/10). Some flaws in study with an associated risk of bias so that associative conclusions are less robust.
Poor	Most criteria are poor or not addressed and significant flaws relating to key aspects of study design are apparent.
Comments	

Operationalisation of Quality Criteria

1 – Well-defined research question

Good	The goal in conducting this research is clearly described The research question, study aims and objectives are clearly defined.
Fair	The research question is outlined but aims or objectives are not clearly specified.
Poor	Research question and aims/objectives not clear.
Not addressed	The research question/aims/objectives are not explicitly identified.
Not reported	It is not possible to ascertain from the report/consultation with database source papers or contact with study authors whether this criterion has been met or not.
Not applicable	
Notes	

2 – Study populations are clearly defined and comparable (selection bias)

Good	Inclusion and exclusion criteria are developed prior to recruitment or selection and same criteria are utilised for all participants. The study describes the group of people from which the study participants were selected or recruited using demographics (who), location (where) and time period (when). Characteristics of the populations from which participants were selected are summarised (preferably in a table).
Fair	Inclusion and exclusion criteria are utilised but it is not clear if these were applied prior to recruitment. Participant recruitment information is described but with one of the 'who, where or when' items missing. Participant characteristics are summarised in the text/table.
Poor	Inclusion or exclusion criteria are mentioned but are not applied consistently or are post-hoc. Participant recruitment information is not well described in a manner consistent with replication. Participant characteristics are minimally described.
Not addressed	The study does not utilise inclusion/exclusion criteria or collate participant recruitment information.
Not reported	It is not possible to ascertain from the report/consultation with database source papers or contact with study authors whether this criterion has been met or not.
Not applicable	
Notes	

3 – Sampling and participation detailed

Good	A sampling method that ensures minimal bias (e.g. probability sampling) is used. Appropriate inclusion/exclusion criteria are applied. More than 70% of eligible participants take part in the research study. Information regarding non-participation rates, reasons and demographic differences between participators and non-participators within (and between where appropriate) study groups are addressed.
Fair	There is potential bias evident in the sampling method. 51-69% of eligible participants take part or inclusion/exclusion criteria limit generalisability.
Poor	The sample is likely to be biased (e.g. self-selected volunteers) or less than 50% agree to take part.
Not addressed	The study does not attempt to address selection bias.
Not reported	It is not possible to ascertain from the report/consultation with database source papers or contact with study authors whether this criterion has been met or not.
Not applicable	
Notes	

4 – Attrition

Good	The study describes the percentage of individuals recruited into the study who dropped out before the study outcome measures were completed. Comparison of completers vs. non completers is reported. Rates are similar for each group (within 10% of each other and 20% of total participants (SIGN 1.5)).
Fair	Study attrition is described but is not statistically analysed. Drop out between groups is within 20% and is less than 30% in total.
Poor	Study attrition is inadequately described, not statistically analysed and/or is high or uneven between groups.
Not addressed	No attempt is made to address issues of participant attrition within or between study groups.
Not reported	It is not possible to ascertain from the report/consultation with database source papers or contact with study authors whether this criterion has been met or not.
Not applicable	
Notes	

5 – Sample size

Good	The authors present reasons for selecting or recruiting the number of people included or analyzed. The statistical power of
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	the study is described and appropriate.
Fair	The study presents a robust rational for sample size but does not include statistical power calculations.
Poor	The study presents a rational for sample size based on pragmatic issues alone and/or does not include statistical power calculations.
Not addressed	The study does not attempt to address issues of sample size adequacy in relation to the research question.
Not reported	It is not possible to ascertain from the report/consultation with database source papers or contact with study authors whether this criterion has been met or not.
Not applicable	
Notes	

6 – Trauma exposure measures/assessment

Good	All exposure measure(s) are defined in detail. The tools or methods used to measure exposure have strong psychometric properties (i.e. validity and reliability). Exposure is measured using a tool that has evidence of reliability and validity for the population studied. Exposure is assessed in the same manner within groups and between groups.
Fair	Standardised measures utilised with adequate psychometric properties but little or no evidence of reliability and validity for the population studied.
Poor	Non-standardised measure(s) used with rational provided e.g. new measure
Not addressed	Non-standardised measures used, no rational.
Not reported	It is not possible to ascertain from the report/consultation with database source papers or contact with study authors whether this criterion has been met or not.
Not applicable	
Notes	

7 - Different levels of trauma exposure are defined and statistically assessed

Good	Range or multiple categories of exposure are described. This may be discrete categories of exposure or exposure measured as continuous variables. Statistical analysis of trends or dose-response relationships between exposures and outcomes is made.
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Fair	Range/multiple categories of exposure are defined but not assessed.
Poor	Range/multiple categories of exposure are noted but not defined or assessed.
Not addressed	No attempt is made to study different levels of exposure.
Not reported	It is not possible to ascertain from the report/consultation with dataset source papers or contact with study authors whether this criterion has been met or not.
Not applicable	.
Notes	

8 - Outcome measures are valid and reliable

Good	Outcome measure(s) are defined in detail. The tools or methods used to measure outcomes have well reported psychometric properties (ie. validity and reliability). Outcomes measure(s) have evidence of reliability and validity for the population studied. Outcome(s) are assessed in the same manner within groups and between groups.
Fair	Standardised measures utilised with adequate psychometric properties but little or no evidence of reliability and validity for the population studied.
Poor	Non-standardised measure(s) used
Not addressed	The study does not address issues of standardisation, reliability or validity of measures used.
Not reported	It is not possible to ascertain from the report/consultation with database source papers or contact with study authors whether this criterion has been met or not.
Not applicable	
Notes	

9 - Main potential confounders identified and accounted for

Good	Key variables that may affect outcome are assessed at baseline and, if applicable, groups are sufficiently alike. Alternatively, potential confounding variables are adjusted for statistically regarding their impact on the relationship between exposure(s) and outcome(s).
Fair	Key variables that may affect outcome are assessed at baseline but differences are not controlled for in the analysis.
Poor	Confounding variables are not identified at baseline but are identified in discussion of limitations.

Not addressed	Does not address the possibility of confounding.
Not reported	It is not possible to ascertain from the report/consultation with database source papers or contact with study authors whether this criterion has been met or not.
Not applicable	
Notes	

10 – Blinding

Good	The study uses methods to ensure that outcome assessors were blind to participants' exposure status. If blinding is not possible assessment of any detection bias that may be present is described in terms of process measures used with each group e.g. frequency or duration of contacts and completeness of observations. The study reports on such process measures and they are similar for each group.
Fair	Blinding method is utilised but the method is likely to have been inadvertently biased. Or blinding methods are used but inconsistently across measures. Or process measures are described however these are reported to vary across groups.
Poor	Blinding method is inadequate. Or process measures are described however variation is not assessed.
Not addressed	Assessors could have realistically been blinded but were not. No indication of process measures.
Not reported	It is not possible to ascertain from the report/consultation with database source papers or contact with study authors whether this criterion has been met or not.
Not applicable	
Notes	